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ABSTRACT

The seventh volume in a 10-volume report on the historical development (1966-1973) of the 8 administrative Area Offices of the Indian Health Service (IHS) Mental Health Programs, this report presents information on the Oklahoma City Area Office. Included in this document are: (1) General Description: Geography and Demography (population; geographic features; and historical development including the Trail of Tears and eastern tribal removals, the 100th meridian, statehood, contemporary Oklahoma, Kansas, and tribes associated with service units); (2) Development of Mental Health Services (non-reservation dilemmas, State services prior to 1969, planning for IHS, first psychiatric staff, Central Oklahoma Service Units, Western Oklahoma, Eastern Oklahoma, and Kansas Service Unit: reservations and Haskell College); (3) Development of Special Mental Health Positions (mental health educator, clerk as entry to mental health worker position); (4) Overview of Oklahoma City Area Mental Health Programs (Area Office; Service Unit staff and activities including stability of personnel, clinical services, and consultation relationships; staff training; and Indian Advisory Board relationships re: planning, coordination, and evaluation); (5) Summary (achievements and problems yet to be solved). (JC)

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Vol. 7, Set 1

ED133111

OKLAHOMA CITY AREA

Service Networks
and
Patterns of Utilization

Mental Health Programs I.H.S.

Partial fulfillment of
Contract No. 110-73-342

U S DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
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OKLAHOMA CITY AREA
MENTAL HEALTH PROGRAMS
OF THE
INDIAN HEALTH SERVICE
1969-1973

1975

IHS Contract No. IHS HSM 110-73-342

A documentary narrative in partial fulfillment of contract entitled:

Service Networks and Patterns of Utilization
Mental Health Programs
Indian Health Service

Prepared by

Carolyn L. Attneave, Ph.D. and Morton Beiser, M.D.

Department of Behavioral Sciences, Harvard School of Public Health

This material has been prepared in connection with an initial evaluation contract to appraise IHS Mental Health Programs seven years after their formal introduction into the system in 1966. (IHS Contract No. HSM 110-73-342) As originally conceived the report was to be based upon a sampling of about three programs in the eight major Areas: One outstanding, one average, and one new or otherwise struggling. Administratively, Area Chiefs of Mental Health and their staffs found it impossible to participate in such a selection, and instead the staff has been required to inform themselves about over 90 programs and present their findings about each as objectively as possible.

The chapter for each Area follows a standard arrangement of information, varying in detail as the Area development indicates. There is first a description of the geographic and cultural context within which Area programs and Service Units work. Secondly, there is a reporting of the historical roots of mental health activities in the Area as far back in time as it has been possible to find evidence of them. In some instances this is coincidental with the formation of IHS in 1955, but in most it appears a few years before introduction of formal budgetted mental health staff. The latter sections of the report develop in chronological order (usually in two year segments) the personnel and activity of the Mental Health programs for the Area. Unique and special programs are presented in detail. Finally, an overview and summary of achievements and problems yet to be resolved concludes the description of the Area, which was completed as of the spring of 1973.

The concluding chapter of the report and the extensive sections on inpatient programs will be of interest to all Areas. It is also hoped that staff in one Area will find it of value to see what other Areas have done or are facing in the way of similar problems, and differing ones. However, when need arises, or interest is focused on only one Area, it is hoped that that chapter may be used as an independent unit.

OKLAHOMA CITY AREA MENTAL HEALTH SERVICES

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PERSONNEL - OKLAHOMA CITY AREA MENTAL HEALTH PROGRAMS

	Tour of Duty
Area Office Mental Health Programs	
Robert Gordon, M.D., Chief	7/69 - 6/71
Liz A. Keahbo, Secretary	9/70 - present
John Bjork, A.C.S.W., Deputy Chief	3/71 -
Chief, Mental Health Programs	7/71 - present
David Larson, M.D., Area Psychiatric Consultant	7/71 - 6/73
George Meyer, M.D., Area Office Consultant (Contract)	7/69
Claremore	
Ronald G. Lewis, A.C.S.W., Mental Health Consultant (also Tahlequah)	1/71 - 8/72
Vicki Wilkerson, B.A., Mental Health Specialist	3/72 - present
Madeline S. Narcomy, Mental Health Secretary	4/72 - present
Gary S. Lounsberry, A.C.S.W.	5/74 - present
Tahlequah	
Isaac Christie, M.Ed., Mental Health Specialist	5/72 - present
Wilma Ummetesekee, Secretary	3/72 - present
Clinton	
Mary Frances Schottstaedt, M.D., Psychiatric Consultant (contract, part time)	1/70 - present
Arthur Rowllodge, Mental Health Specialist	5/71 - present
Jobyna Toppah, Secretary	1/72 - present
Ellen Collin, B.A., Mental Health Trainee	6/73 - 8/73
Pawnee	
Donald Sampson, Ed.D., Mental Health Consultant	6/71 - present
Lavina W. Wichita, LPN, Mental Health Specialist	3/72 - present
Wilson Moore, Mental Health Technician	4/72 - present
Tishomingo	
Phyllis J. Roller, B.A., Mental Health Specialist	5/72 -
H. C. Townsley, M.D., Psychiatric Consultant (part time contract)	9/73 - present
Talihina	
Patricia L. Silk, RN, Mental Health Trainee	6/72 - 9/72
Jorge Ferris, M.D., Psychiatric Consultant	7/72 - 5/73
S. Lynne McAllister, M.S., Mental Health Specialist	8/72 - present
Timothy Nolan, M.S., Mental Health Consultant	6/73 - present

McAlester

George R. Day, M.S.W. (FMS Program)	7/73 - present

Lawton

Richard R. Downey, M.S., Mental Health Consultant	11/72 - present
Thomascina T. Gachot, Mental Health Technician	3/74 - present
William Davies, M.D., Psychiatrist (part time contract)	

Shawnee

Mary Frances Schottstaedt, M.D., Psychiatric Consultant(contract)	7/73 - present
Josephine E. Wise, LPN, Mental Health Technician	6/74 - present

Kansas - Haskell

James R. Bonnar, M.D., Psychiatric Consultant, MHCD Program	7/73 - present
Barbara Ramirez, Mental Health Technician	5/74 - present

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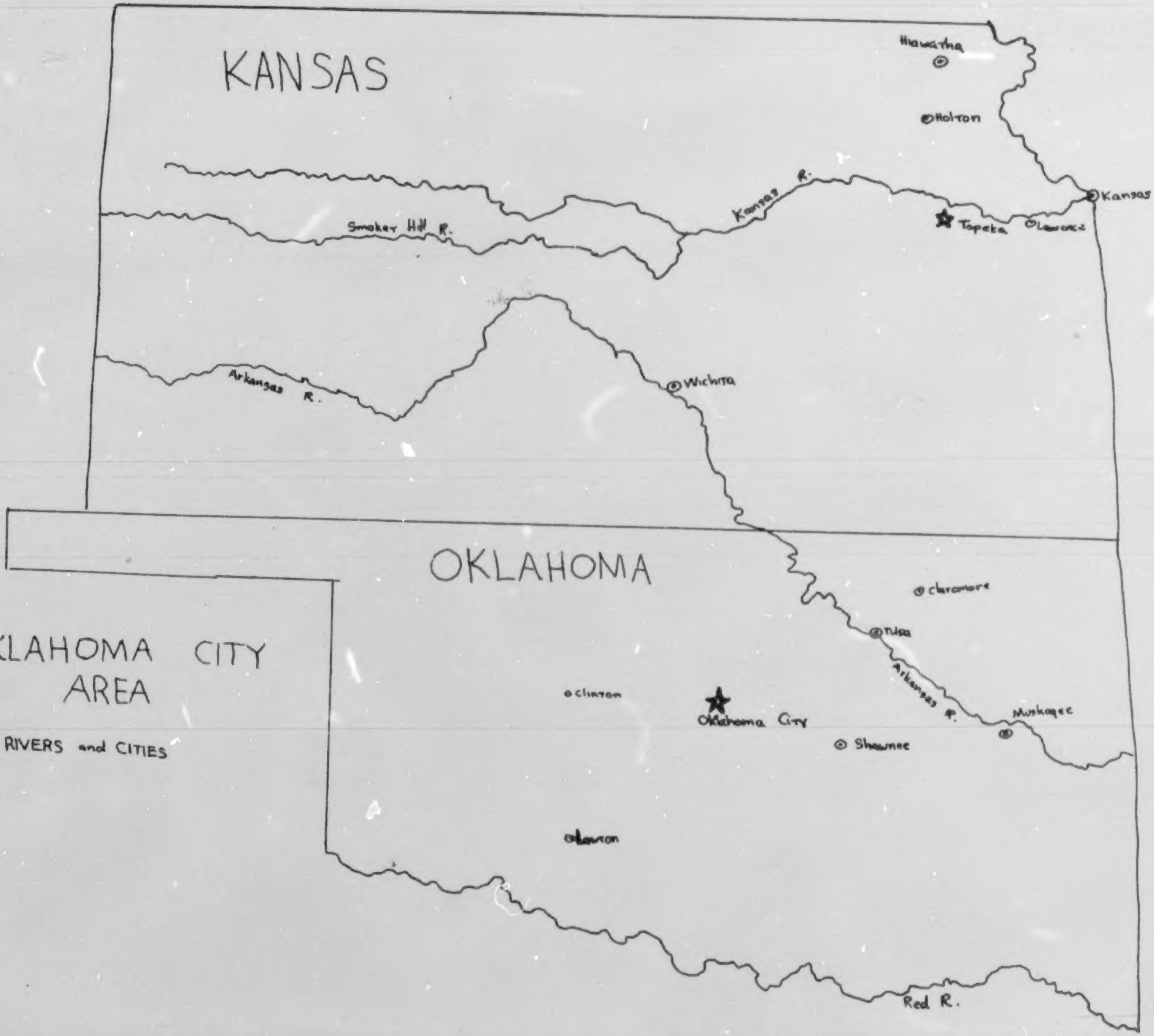
OKLAHOMA CITY AREA

RIVERS and CITIES


KANSAS
Hiawatha
Holton
Kansas City
Topeka
Lawrence
Kansas R.
Smokey Hill R.
Arkansas R.
Wichita
OKLAHOMA
Claremore
Tulsa
Arkansas R.
Muskogee
Clinton
Oklahoma City
Shawnee
Lawton
Red R.

OKLAHOMA CITY AREA MENTAL HEALTH PROGRAMS

I. General Description: Geography and Demography[1]

A. Population

Oklahoma itself has the largest population of American Indians of any of the states. The 1970 Census lists 96,468 identified American Indians out of a total population of 2,559,229. Of these 35,338 are listed as living in metropolitan areas near major urban centers, or in these cities, while 66,822 live in rural settings. Oklahoma City, Tulsa, Lawton, and Fort Smith (which spills into Oklahoma from Arkansas) are major metropolitanized areas of Indian population, while other communities of 10,000 to 50,000 having large Indian populations include Midwest City, Shawnee, and Muskogee. In none of the urbanized metropolitan areas do the Indian populations exceed the counted Negro population, with the exception of the Oklahoma portion of Fort Smith on the Arkansas border. This also seems to hold true for the census reports from smaller towns but not consistent with county totals, where proportions are frequently reversed. This indicates that those Indian people not in cities are largely scattered away from population centers and located in small farms or isolated dwellings.

The accuracy of federal census counts of minorities and of rural populations is always subject to question, and in these kinds of circumstances

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[1] Until 1971 the Oklahoma City Area office was responsible for overseeing not only Oklahoma and Kansas Service Units as is presently the case, but also the territory now under the organization of the United South Eastern Tribes, which included a pocket of Indian population along the coast of Texas, and major reservations in Florida, Mississippi and North Carolina. So far as Mental Health programs were concerned, little except casual contact could be maintained at such a distance, and the development of programs by the United South Eastern Tribes should be treated as a separate unit. Focal activity originated in Oklahoma, and included Kansas through Haskell Institute.

Indian populations living on reservations develop their own roll and census data for more accurate records and use. In Oklahoma, the fact that reservations as such do not exist, and have not since statehood in 1907, makes it much more complex to secure accurate estimates. The thirty-seven tribes resident in Oklahoma do have tribal rolls, but many include persons not residing in the state. Although the World Book Encyclopedia, authority for quiz games and contests, asserts that the Indian population of Oklahoma is seven per cent of the total, and calculations from all sources indicate that as everywhere else it is increasing rapidly, yet the Census of 1970 indicates only about 3.4 per cent.

The IHS Area office and the BIA have developed Indian population figures which they believe more accurately reflect their service needs. According to these figures the 1973 Indian population for Oklahoma was estimated at 108,602. Eighty-three per cent of this population or 90,253 Indian people were defined as the service responsibility of IHS, while 16.9 per cent or 18,349 who lived in the cities of Oklahoma City and Tulsa were not at present receiving services, although IHS is assisting the Oklahoma City Indian Urban Health Project to study this problem. These population figures (locally verified) are more accurate for planning purposes than the federal census records, and are continually being revised through the cooperative efforts of the BIA and tribal offices throughout the state.

The accompanying table illustrates the distribution of the non-urban Indian population and its density.

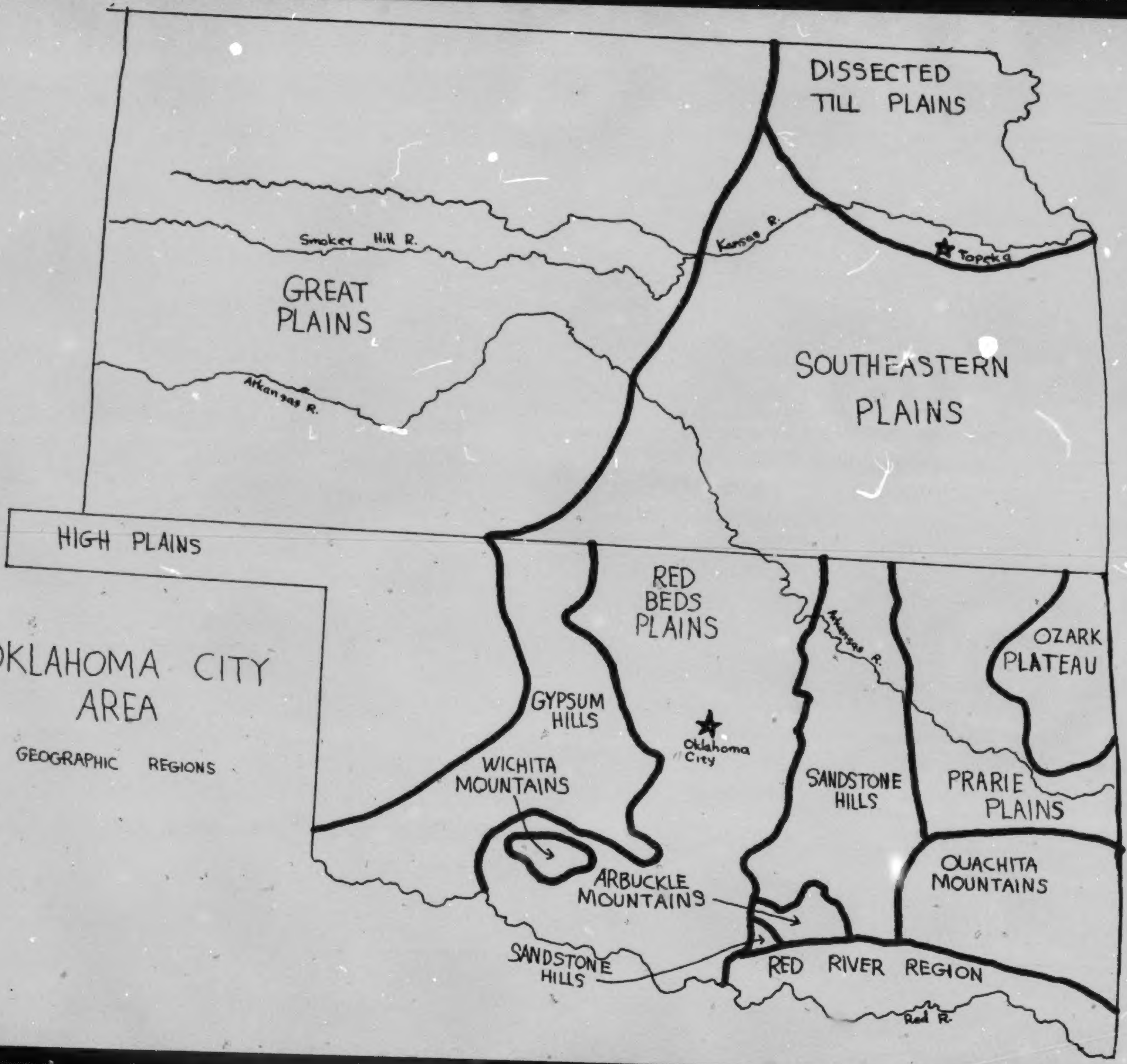
INDIAN POPULATION AND AREAS SERVED BY IHS SERVICE UNITS IN OKLAHOMA

	Area in Square Miles	Estimated Indian Population FY-74
Pawnee	7,281	7,357
Claremore	7,637	33,496
Tahlequah	3,557	16,566
Talihina	9,294	9,287
Tishomingo	6,249	6,672
Shawnee	5,182	20,542
Lawton	11,662	10,292
Clinton	20,763	4,390
OKLAHOMA AREA TOTAL	71,625	108,602

Density of Indian populations will be seen as much higher in the eastern than the western half of the state, in the vicinity of the capitols of the Five Civilized Tribes, and in and around the Shawnee. Elsewhere there is a rough average of one Indian person per square mile. To a certain extent these same patterns mirror population distribution generally throughout the state.

The Kansas Service Unit has responsibility for small reservations, in the traditional sense of the word, which are populated by residual members of the Kickapoo, Sac and Fox, Pottawotomie and Iowa tribes who did not move to Oklahoma. All of these tribes have kin in Oklahoma, mainly in the Shawnee vicinity, and there is a fair amount of traffic back and forth for visiting, ceremonials, and other exchanges. Pockets of Chippewa, Munsee-Delaware, and Wyandott also live in the Lawrence, Kansas City quadrant of the state, but are without trust land, and in somewhat confused status regarding eligibility for federal services.

Indian and Alaska natives from all parts of the United States are eligible to attend Haskell Institute, which is the only college level school


OKLAHOMA CITY AREA

GEOGRAPHIC REGIONS

DISSECTED TILL PLAINS
Kansas R.
Topeka
Smoker Hill R.
GREAT PLAINS
Arkansas R.
SOUTHEASTERN PLAINS
HIGH PLAINS
RED BEDS PLAINS
Arkansas R.
OZARK PLATEAU
GYPSUM HILLS
Oklahoma City
WICHITA MOUNTAINS
SANDSTONE HILLS
PRARIE PLAINS
ARBUCKLE MOUNTAINS
OUACHITA MOUNTAINS
SANDSTONE HILLS
RED RIVER REGION
Red R.

operated by the BIA. It is located on the grounds of the University of Kansas at Lawrence. Ten additional BIA schools or dormitories in Oklahoma also receive students from all United States reservations and Alaska.

B. Geographic Features

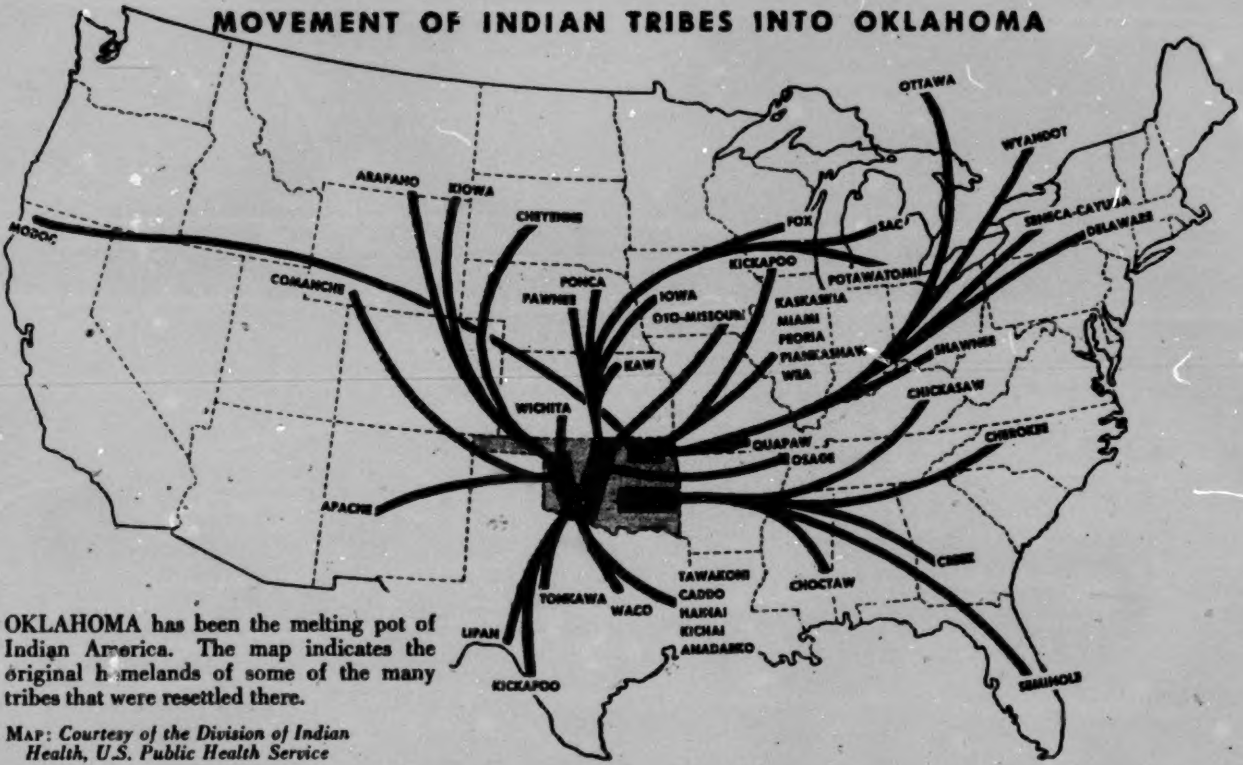
There are both historical and geographic reasons for these distributions of Indian peoples. Since to a certain extent geographic features determine history, a quick look at the major features is probably in order to set the stage. Paradoxically the highest, and the most level, not to say flat, regions of the state are in the northwest, where Oklahoma shares high plains that stretch from the Texas panhandle to the Canadian border, and give the Dakotas, Montana, Colorado and Wyoming their characteristic broad sweeps of horizon. The Black Mesa of Oklahoma is approximately 5,000 feet elevation and is a tableland. Variations of 100 feet in elevation are sufficiently infrequent through this western region as to produce muscle cramps when hiking. Hills that would go unnoticed elsewhere are used as local landmarks.

These high plains descend eastward across the state through Gypsum Hills, sometimes know as "Glass Mountains," and Red Plains, named for their characteristic clay colors. They merge with sandstone hills until they meet the Ozarks along the eastern border and the Arbuckle and Wichita Mountains along the southern length of the state. The Arbuckle and Wichita Mountains are quite old, sometimes rising only 600 to 700 feet above the plains, but have been carved into steep valleys by the tributaries of the two main river systems, the Red River which is the Texas - Oklahoma border, and the Arkansas, which curves across the northeastern quadrant. The Canadian River, with various forks and branches flows east across the midsection of the state eventually joining the Arkansas. Numerous lakes, many formed by dams, have markedly changed the climate and topography of the eastern half of the state in the last ten years. Recently dredged channels and locks connecting these lakes and the older rivers enable Tulsa to be a deep water port for international shipping.

The Oachita Mountains, a spur of the Ozarks in the souteast corner extending into Arkansas, are fairly rugged, and not well settled. They are famous for the hiding places offered to escaped outlaws, and for being part of a militant but impoverished section known as "Little Dixie." Lumber, coal, and some other mining is characteristic of the industrial development of the mountainous eastern region, with fruit and pecans also major resources in some sections. Oil development tends to be centered in the northeast and to follow the sandstone and clay formations. Cotton, wheat, rye and cattle are characteristic products of the western half, and of the open sections of the state. It is the western two thirds of Oklahoma that are characteristically the country associated with the "Dustbowl" of the depression.

The major cities are Oklahoma City, the capital, located in the approximate geographic center, and Tulsa, about 100 miles northeast. Towns of 10,000 to 50,000 include Lawton, 80 miles southwest of Oklahoma City where the bulk of the population is accounted for by the artillery and army installation at Fort Sill, Enid, Pawnee, Shawnee, Ponca City, Clinton, Norman, Stillwater, Bartlesville and McAlester. These have grown from frontier settlements to small city towns for a variety of reasons. Of these only Clinton and Lawton are west of the Oklahoma City metropolitan area, and Clinton is the only one in the high plains region.

Kansas has roughly the same east-west characteristics as Oklahoma, since it lies directly north. The flat plains or prairies extend somewhat fur-



MOVEMENT OF INDIAN TRIBES INTO OKLAHOMA

MODOC
COMANCHE
ARAPAHO
KIOWA
CHEYENNE
PONCA
PAWNEE
IOWA
OTO-MISSOURI
KAW
WICHITA
APACHE
LIPAN
KICKAPOO
TONKAWA
WACO
TAWAKONI
CADDO
HAINAI
KICHAI
ANADARKO
OTTAWA
WYANDOT
FOX
SAC
KICKAPOO
POTAWATOMI
KASKASKIA
MIAMI
PEORIA
PIANKASHAW
WEA
SENECA-CAYUGA
DELAWARE
SHAWNEE
CHICKASAW
QUAPAW
OSAGE
CHEROKEE
CREEK
CHOCTAW
SEMINOLE

OKLAHOMA has been the melting pot of Indian America. The map indicates the original homelands of some of the many tribes that were resettled there.

Map: Courtesy of the Division of Indian Health, U.S. Public Health Service

5a

ther east, and the hills along the west are more gently rolling, and not characterized by prominent mountains. The Service Unit at Horton is in the northeastern corner of the state in lightly wooded farm country and includes several small reservations near Horton and Holton, as well as Haskell Indian Community College on the grounds of the University of Kansas at Lawrence, which lies between Topeka and Kansas City.

C. Historical Development

Until 1819 the territory of Oklahoma was ambiguously owned by Spain, having been partially explored by Coronado as early as 1541. Although French missionaries and trappers had been present since the 1600's, it was not clear whether Oklahoma had been included in the Louisiana Purchase of 1803 or whether title to at least part of it remained with Spain. There was no feeling of urgency about settling this matter until the westward movement increased the attractiveness of the land. Osage, Caddo, Wichita, Comanche and Kiowa tribes used the high western plains for hunting buffalo, and Kiowa and Apache used the hills of the west for more permanent camps, to trap and gather roots, nuts, acorns, and furs. However, to most United States citizens it was empty country, too close to Kansas City to satisfy the westward urges, and not fertile enough to tempt many to stop off and homestead.

1. Trail of Tears and Eastern Tribal Removals

In 1820 President Andrew Jackson ordered that it be declared Indian Territory, and also ordered the removal of the eastern Indians, particularly those in the Southern states. These Southern Indians have incorporated themselves as the Five Civilized Tribes - the Cherokee, Creek, Chickasah, Choctaw and Seminole. Their removal led to an uprooting known in one version or another to each tribe as a Trail of Tears," which continued until 1846. These tribes, with the exception of the Seminole in Florida, had largely assimilated themselves into the various stratification of the white majority and many were prosperous plantation owners, business men, and scholars who deeply resented the discrimination and unfair confiscation of their lands in Georgia, Alabama, Mississippi and the Carolinas. They chose land in the eastern half of the territory, much of it resembling the hilly country which they had left. They soon established the first newspapers, first grist mills, first cotton gins, and first schools in the Indian territory that later became Oklahoma. These accomplishments, as well as their contemporary modes of blending Indian and white cultures, have given a ring of verity to their self chosen title of "Civilized Tribes."

Other eastern tribes from the Great Lakes and prairies were also sent into the Territory. There is an ironic story that the Cherokee scouts could have chosen the Osage lands slightly north and west, but felt that there were not enough trees and water to support squirrels, let alone themselves. The later discovery of oil made the Osage, who had held mineral rights in trust, a very rich tribe for a while. There was relatively little oil land or discovery which led to Cherokee fortunes.

During the Civil War the Five Civilized Tribes were divided in their loyalties, and many served with the Confederacy. In the aftermath they were made to sign away much of their lands and to give away many of their treaty rights. This was federally justified as reprisal for containing Confederate sympathizers, and in some cases in revenge for defensive actions against Northern troops in rather confused skirmishes.

2. The 100th Meridian

That part of the state west of the 100th Meridian, known as the Oklahoma Territory, was dominated by a large fort at Lawton (Fort Sill), where Apache, Kiowa, and Comanche leaders, and even whole tribes, were imprisoned. In later years these tribes were given land allotments in the southwest regions of the territory or state. The Cheyenne and Arapaho, after defeats in the North following the Battle of Wounded Knee, were removed to the high plateaus of western Oklahoma, where a portion of each tribe remained while another portion refused and resettled in Montana and Wyoming (See Billings Area Chapter).

Tribes from the Great Lakes Area were finally resettled in central Oklahoma after a sojourn in Kansas. These tribes, the Kickapoo, Pottawotomie, Iowa, and after the Black Hawk War, the Sac and Fox, presently all have an Oklahoma tribal organization as well as small reservations elsewhere that are separately organized. The midwestern prairie tribes of Pawnee and Osage were settled in the north central sections among the sandstone hills.

The 100th Meridian which bisects Oklahoma between Oklahoma City and Shawnee became a boundary line between Indian Territory and land opened up for settlement. Since early emigrants chose the open fertile prairie for homesteading, the western side of the Meridian was called Oklahoma Territory, and the eastern side remained Indian Territory. However, the dream of a single Indian Territory where all tribes might live according to their own customs succumbed to land hungry lobbyists in the 1880's. Instead, each individual Indian was alloted land (approximately forty acres per man, woman or child) and all unalloted land opened up to claims for homesteading. The great land rushes began officially in 1889, but some settlers managed to establish themselves before this time and were known as "Sooners," the state nickname.

The Dawes Commission, established in the 1890's, continued the land allotment system, and attempted to set dates by which time the Indian people would be self sufficient and no longer need federal services. However, the Oklahoma tribes managed to retain many of their treaty benefits, including health services, and the Bureau of Indian Affairs and its predecessors establisblished agencies in each of the two territories (Muskogee in the east became the Agency for Indian Territory and the Anadarko Agency handled the tribes west of the 100th Meridian).

Significant portions of some of the tribes who were alloted land refused to sign treaties, or simply kept moving west and south and negotiated status much later than the original group. This created a second tribal entity in several instances such as the Absentee Shawnee and the Western Delaware. In the case of the Kickapoo, a large percentage hold Mexican land and citizenship as well as their family allotments in Oklahoma or their reservation residence in Kansas. These latter groups that later accepted land tend to be located in the southern and western sections of the state, while their older population representatives following the lead of the Five Civilized Tribes are located to the east of the 100th Meridian. The differences in attitude persist in many ways, particularly in political action and in the acculturated status of members, making Indian politics in Oklahoma complex and adding color to state politics as well. It is worth noting in passing that what later became the first hospital and also the first boarding school for Indians were established at Fort Sill, Oklahoma, as part of a treaty with the Apache. These institutions are still viewed possessively by this tribe, and there is great distrust at any effort to modify the original treaty provisions.

3. Statehood

Impetus and leadership in the effort to change Territorial status to Statehood came equally from the Five Civilized Tribes and from the western white settlers. Although two separate states were at one time envisioned, statehood was finally achieved by merging the Indian Territory with the Oklhoma Territory and officially admitting a single state to the United States in 1907.

The end result of these historical trends is a state which like Alaska has no reservations, even though tribes tend to be concentrated in the areas near the original allotments of land. The State constitution does not differentiate rights or privileges of white or Indian citizens, declaring all to be residents and equal beneficiaries, as well as equally responsible to state laws.

4. Contemporary Oklahoma

During the period when Oklahoma had separate schools for black children, Indian pupils were accepted into white schools. The Indian people gradually adapted to the utilization of local public schools, although in the present adult generation a great many parents over thirty and most grandparents received a major part of their education in federal boarding schools. In the last decade there has been a noticeable increase in interest among rural Indians in securing fair treatment for their children in public schools, even to the point of running for office on local school boards.

Prejudice and discrimination appear paradoxically in many ways in the fabric of day to day activities. There is respect for Indian personalities who have become famous; Will Rogers, for instance. There are unrecognized contributors such as the Osage warrior who became a General for whom Tinker Air Force Base is named. Indian place names and a certain percentage of Indian blood are often marks of distinction and frequently boasted about even though the connection is historical.

Yet living in the state one becomes aware of two cultures in emulsion - not fused or synthesized. It is possible for non-Indians to live without more than occasional casual awareness of the activities, feelings, and living traditions of the Indian population in their midst. Awareness is often sporadically thrust upon one by sensational events. Many are positive, such as a museum exhibit, the Anadarko Intertribal activities or the Tsa La Gai pageant of the Cherokees, an award at the Cowboy Hall of Fame or for athletic prowess. In fairly recent times Indians for Oklahoma Opportunity has attempted to publicize a more diverse list of achievements and build contemporary recognition by both Indians and non-Indians. However, some of the publicized events are not only negative but degrading, as in the case of criminal reports, school dress code controversies or accusations of political mismanagement of tribal resources.

More difficult to detect is a callousness which presumes knowledge that is really very shallow but is, unfortunately, often characteristic of public officials. For instance, about ten years ago it was possible to use an Indian theme at the State Fair without a single Indian organization exhibiting or participating.

Prejudice is usually expressed more subtly. Long before any crisis in lack of paper supplies an Indian housewife would be charged a nickel for the paper bag to carry home her "four bits" worth of potatoes, while the bag was supplied automatically to the white customer before and after her in line. Recently a suit was brought against a community hospital for refusing to admit and treat Indian patients even in emergencies, and even when they could pay for private care. The daily impact of discrimination is usually felt more keenly as one travels westward across the state.

In the southeastern quadrant intermarriage and emphasis on individual worth are more common, while in the west, especially the northwest, the Indian may refuse to sit next to a white person, as a reflection of multiple rejections.

Since Indians in Oklahoma are not segregated onto reservations, and since they pay taxes, own land, vote and are subject to the same laws as other citizens, they should receive the same services. The State Department of Public Health and its County Health Departments do include Indian populations in their planning, yet they frequently feel that IHS should reimburse them for care provided. Recent negotiations are being based on the over-representation of Indian children receiving services.

These positive signs are usually pointed out with pride by top level authorities when questions relating to Indian affairs are brought to their attention. However, the implementation of policy decisions are not always easy on the local level, where attitudes and habits clearly affect day to day service delivery.

This is as much a problem among Indian populations as it is among the non-Indian groups. The range of cultural systems and differing attitudes of the tribes themselves toward assimilation make planning difficult when all must be pleased. Some tribes, until very recently, ostracized members who became assimilated. Other tribes have conscientiously worked toward teaching their children to live in both an Indian and a white man's style. The complexity of thrity-seven separate treaties is further embellished by the fact that a number of BIA boarding schools were built around Oklahoma, and Indian and Alaska natives from all over the United States sent there to school. Many intertribal marriages resulted, and many who came to school remained, feeling better able to fit into Oklahoma life than to return to their reservations.

5. Kansas

Kansas had been the stopping place for many tribes pushed south and west by the westward expansion of the United States population. The Iowa, Kickapoo, Pottawotomie, and Sac and Fox tribes retained some lands in the northeast quadrant, and still have reservations there although each also is represented in the Oklahoma Indian population. Haskell Indian College, under BIA auspices, is located on the grounds of Kansas University at Lawrence, Kansas, and together with these reservations is given health care by the Oklahoma City Area Office of IHS.

6. Tribes Associated with Service Units

With this quick overview, the detailed description of each of the nine Service Units of this area will be more clearly set in perspective. Each will be described as the particular Mental Health Programs developed by them is presented. However, as a way of summarizing, the following table lists the names of each Service Unit, and those tribes which it serves.

"INDIAN TRIBES OF OKLAHOMA AND KANSAS
SERVED BY THE
OKLAHOMA CITY INDIAN HEALTH AREA

(The following thirty-six Indian tribes are represented on the Service Unit Advisory Boards in nine Service Units of IHS, and have certified members and alternates to the Area Board.)

Kansas Service Unit
Iowa Tribal Executive Committee
Kickapoo Tribal Business Committee
Prairie Band Pottawotomie Tribal Business Committee
Sac and Fox of Missouri Council

Claremore Service Unit
Cherokee Nation of Oklahoma
Creek Nation of Oklahoma
Cherokee-Shawnee Tribe of Oklahoma
Delaware-Cherokee of Oklahoma
Eastern Shawnee Tribe of Oklahoma
Miami Tribe of Oklahoma
Osage Tribe of Oklahoma
Quapah Tribe of Oklahoma
Seneca-Cayuga Tribe of Oklahoma
Wyandotte of Oklahoma

Clinton Service Unit
Cheyenne Tribe of Oklahoma
Arapaho Tribe of Oklahoma

Lawton Service Unit
Caddo Tribe
Comanche Tribe
Delaware Tribe of Western Oklahoma
Fort Sill Apache Tribe
Kiowa Tribe
Kiowa-Apache Tribe
Wichita Tribe

Pawnee Service Unit
Kaw Tribe
Osage Tribe of Oklahoma
Otoe-Missouri Tribe
Pawnee Tribe
Ponca Tribe
Tonkawa Tribe

Shawnee Service Unit
Absentee Shawnee Tribe
Creek Nation of Oklahoma
Citizen Band of Pottawotomie Tribe
Iowa Tribe of Oklahoma
Kickapoo Tribe of Oklahoma
Sac and Fox Tribe of Oklahoma
Seminole Nation of Oklahoma

Tahlequah Service Unit
Cherokee Nation of Oklahoma
Creek Nation of Oklahoma

Talihina Service Unit
Choctaw Nation of Oklahoma

Tishomingo Service Unit
Chickasaw Nation of Oklahoma

Area Information Services
May 1973"

II. Development of Mental Health Services

A. Non-Reservation Dilemmas

Perhaps because of its multi-tribal composition, the voice of Indian needs and demands has seldom been clearly articulated in Oklahoma. There is also a real confusion in much of the legislation and federal regulations, which in spite of the fact that Oklahoma has no reservations keep phrasing all funding, criteria for services, etc. in terms of reservation units. An additional problem, so far as Mental Health Programs have been concerned, is ambiguity about the role of the State of Oklahoma itself - if Indian residents are citizens, then the Public Health and Mental Health facilities should be open to them in the same fashion that the newer constitution in Alaska provides.

There are blinders on both sides, and there has been intermittent activity on the part of IHS to develop an aggressive Oklahoma policy in building networks of statewide support at the county and institutional level, as well as at the level of state government. Perhaps, because of internal rivalries in Oklahoma politics, as well as a scarcity of resources generally, IHS staff may have often felt that one tangled web of relationships was enough, and have concentrated just on building tribal supports. More recently there has been active effort to establish inter-agency cooperation appropriate to the peculiar situation of Indians in Oklahoma. The only parallels for IHS are found in Alaska, and are relatively unknown. This has made some IHS policy ambiguous and difficult to administer in non-reservation settings.

For whatever reasons, the development of Mental Health Programs must be seen against this background. The emergence of effort to implement Area programs and to establish a statewide interlocking network of the sort that might be envisioned is quite a different challenge than that faced in other IHS Areas.

B. State Services Prior to 1969

The initial efforts to establish within the IHS a Mental Health Programs operation followed some fairly lengthy work by the Social Services Branch, including efforts to introduce psychiatric nursing and social workers to the BIA schools. These attempts, prior to 1969, were rather abortive, since there was no Area support for a special staff and the liaison between

BIA and IHS was not strong. There are two BIA Agency offices in Oklahoma; one in Muskogee, concerned with the Five Civilized Tribes and those smaller groups that were alloted land near them, and the other in Anadarko, which handles the affairs of the western half of the state. The Service Units at Shawnee and Pawnee serve both types of clientele and must relate to both BIA Agencies.

Social Service Personnel of the BIA tended to be drawn into the network of the State and County Health Departments which provide child guidance centers as resources to the local Indian populations. They also relate fairly easily to the State Hospitals (Eastern State at Vinita, Western State at Weatherford and Central State at Norman). IHS Service Units until 1969 had few or no specially trained personnel available to fill Mental Health roles, and most relationships between IHS and local Community Guidance Services were exchanged through contacts with parallel personnel in the Public Health Nursing staffs. How much local state and county units were invloved with IHS usually depended upon individual interest on the part of County Health Officers and the skills of the Community Guidance Services, as well as IHS interests. A highly concentrated program in Pottawotomie County (Shawnee), Community Guidance Services, had succeeded in involving Indian populations, and the network of related agencies, at a level equal to their representation in the population (40%), while some of the same staff in neighboring Seminole County were only approaching this criterion. With later changes in County Health Department personnel, the Indian percentage of utilization dropped to 3 - 5% over a three or four year period.

Unfortunately, the introduction of Mental Health Programs by IHS seemed to non-federal resources as if it were started de novo with little consideration of already established local professional resources. This assumption could have been reasonable for a reservation based Area, but actually undermined the preceding ten years of local liaison work by some local Indian leaders. IHS appeared for a while to be offering the false flag of hope for an all Indian Mental Health Service independent of state and county. It also overlooked the community mental health efforts of the then federal authority for such work in the State Department of Health by emphasizing relationships with the Department of Mental Health which in 1969 had responsibility only for Institutions. This last was an easy error to make, particularly for a federal service that had at that time very little experience with non-reservation Indian populations and for psychiatrists with no background in Oklahoma state politics. In all fairness, it should also be pointed out that IHS program development had to start somewhere, and the energetic liaison with the various tribes was a good choice. This initial relationship continues to be viable and provides a strong base for developing more extended networks.

C. Planning for IHS by George C. Meyer, M.D.

The preliminary planning for IHS done by Dr. George Meyer was sensitive to the need for local community involvement and, in implementing the program, IHS staff concentrated on local Indian units of organization. This was also the point of view shared by Dr. Jack C. Robertson, then IHAD for Oklahoma, who had a deep interest in the potential value of IHS Mental Health Programs. The importance of Dr. Robertson's support and his ability to attract consultants of a high caliber of expertise should not be minimized. In 1968, he requested that Dr. Meyer make a survey of the potentials for developing a program of Mental Health Services for the Oklahoma City Area.

Dr. Meyer's recommendations have formed the backbone of the programs that subsequently developed in the Oklahoma Area; therefore, his report of the assessment of the potentials for establishing IHS Mental Health Programs is quoted in full below. Some of his principles and recommendations are only now being implemented, although all three phases that he projects for Mental Health Program development have been introduced at some level in some parts of the program.

THE UNIVERSITY OF CHICAGO
CHICAGO • ILLINOIS 60637
DEPARTMENT OF PSYCHIATRY
950 EAST 59TH STREET

August 1, 1968

Dr. Jack C. Robertson
Indian Health Area Director
Department of Health, Education
and Welfare
506 Petroleum Club Building
Oklahoma City, Oklahoma 73102

Dear Dr. Robertson:

The following observations and suggestions constitute my report to you regarding the establishment of a mental health program for Division of Indian Health beneficiaries in Oklahoma. They encompass a previous summary to you of the meeting with tribal leaders in May 1968. They are based upon a 3-day visit to Oklahoma which included an opportunity to meet with tribal leaders, area office personnel, and field personnel. Included were site visits to Chilocco Indian Boarding School and Central State Hospital in Norman. Background preparation, in addition to my own 2-1/2 years in the Division of Indian Health, and my subsequent psychiatric interests, included a visit to the mental health programs in Window Rock, Arizona, and Albuquerque, New Mexico. Lastly, I appreciated the opportunity to attend the mental health meetings of the Division of Indian Health in Albuquerque, New Mexico on June 11, 12, and 13, 1968.

There are a number of difficulties in making any recommendations on the basis of even the exposure outlined above. Administrative and budgetary limitations, directions of policies adopted at various levels, and similar considerations limit the usefulness of one individual's viewpoints. It should be obvious that I view my own contributions as being enhanced by the opportunity to return periodically, and to maintain and expand contacts meanwhile.

PRINCIPLES

Several principles will underlie the recommendations that do follow:

(1) There is a great need for surveys to assess the mental health needs of the community through objective data on the prevalence of mental disorder.

(2) There is a similar need to understand the relationship of the beneficiary population to the available resources in the community through the study of the actual care of the mentally ill, and of the attitudes of family and culture in general towards these resources.

(3) There is need for coordination of the mental health program for the Indian population over the long haul with the development of the comprehensive community health centers and similar movements providing service for rural and deprived populations;

— there are nonetheless special needs, as well as special assets, in working with the beneficiary Indian population at present.

--(4) There is an increasing need to involve the Indian population in planning for mental health needs, in assessing priorities, in administrating programs, as well as in actual staffing, supervisory and advisory functions.

(5) Like with the establishment of community mental health centers, treatment should be available near home, as quickly as possible, with a minimum of disruption of family and work ties.

(6) The administrative structure of the mental health program should be along program lines rather than mounted along the lines of particular professional disciplines. The best person to organize a program in a given area should head it, based on his knowledge and capacities rather than on his or her affiliation.

PLANNING PHASES

I foresee 3 phases in planning.

Phase I would consist of listening and planning with the Indian population, setting up a communications system with State and other local facilities, and providing some psychiatric consultation and training functions. Especially important in this phase would be the setting up of local advisory and planning mental health boards, to include at each field station representatives of the local population served, a representative of the local community, and those interested field health staff whose work is in the broad mental health area. Bureau of Indian Affairs staff should wherever possible be involved in planning and coordination, and should be represented on local mental health boards. One person at each field station must be designated the coordinator for that unit. Finally, the designation of one area level person to coordinate the program and to communicate with local field level mental health boards will be crucial. Each field program would contribute one member to an area-level mental health board.

One of the functions of an area-level mental health board would be to determine the relative weight to be given to research, education, treatment, and preventive projects.

In Phase I consideration should be given to the establishment of a "hot line" kind of emergency consultation to the area office for management of acute crises in the field. Increased utilization of the State-run referral facility would be a desirable goal. Utilization of the Chicago-based psychiatric consultation, and of more mental health professionals on a contract basis, would be helpful. A "telephone clinic" may be utilized during the psychiatric consultant's visits to Oklahoma, in which, after mutual exposure, field units could discuss psychiatric cases over the phone with the consultant. The Federal Tele-Communications System should be used for such emergency telephone consultations.

Phase II would aim primarily at recruitment and training of mental health workers, with beginning provision of services. Relevant here would be the selection and supervision of so-called indigenous nonprofessionals, as well as the acquiring of a psychiatrist and/or psychologist team leader, additional social work staff, and the establishment of a "line-item" budget. Set up during this phase would be regular consultation services to schools, regular workshop participation for field health staff and perhaps boarding school staffs, and regular psychiatric clinics.

Phase III would consist, subject to further planning and approval by an area wide advisory board, of the setting up of an inpatient psychiatric facility, probably emphasizing the treatment and rehabilitation of alcoholic patients. Relevant to the needs of the populations I surveyed was the establishment of a locked ward for acutely disturbed patients, as well as the provision of after care for a transitional period. In addition, a half-way house, a sheltered workshop, and a vocational training center would provide service, consultation, and further training for both staff and beneficiary populations.

A long-term goal might be the setting up of a close circuit T.V. kind of arrangement such as is in operation at the Nebraska Psychiatric Institute for State wide discussion of clinical problems.

Another long-range goal might be the establishment of contract transportation by air to field facilities, such as being done on the Navajo Reservation out of Gallup and Window Rock. This item, although expensive, provides maximal availability of clinical staff at the site where clinical help is needed.

OBSERVATIONS AND COMMENTS

1. There is a growing awareness of mental health needs evident in tribal leaders, the beneficiary population in general, and DIH and BIA staffs. The expansion of staff meetings, liaison committees, awareness of need for treatment resources for employees, and even the uneasiness regarding promotions and hiring of Indians on a preferential basis have a healthy aspect to the unrest, in the eyes of this observer. The continuation of such resources as the workshop, the informal or formal gripe session, and even the question of a retreat or ongoing sensitivity training experience for staff may well continue this trend towards more openness in communication.

2. The impression I had been given by tribal leaders regarding their distrust of State-run psychiatric facilities was confirmed when I visited Central State Hospital. There are however aspects of that program which could be utilized by the Division of Indian Health to great advantage. It is a training resource for staff which could be of mutual benefit. For example, physicians, nurses, and social workers could be exchanged for one month periods. Indian health workers might gain a great deal from a period of training at that hospital. The resources available there in the form of the sociologist, a geneticist, and a social anthropologist, could be helpful in setting up and evaluating research projects in the field. It would be very worthwhile to know the actual number of Indians treated in the State system, as well as the outcome of that treatment by a follow-up.

3. The relationship between the Division of Indian Health and the Bureau of Indian Affairs obviously deserves continued efforts at all levels for cooperation and mutual give and take. It is self-evident that the beneficiaries, especially the children, and in Oklahoma, especially the children in boarding schools, should not suffer just because two "parents" are fighting. This report is not the place for a long resume of the difficulties, or

even of the issues involved. It is however a place where I can recommend that all efforts be made to increase the number of Indian parental figures available to the boarding school children. This means advising a great increase in the number of instructional aid positions. It means supporting expansion of all volunteer programs. It means advising the settlement of the issue of who transports a child to town, and who pays for such transportation when it is needed.

4. Further possibilities for cutting across disciplinary lines would be integration of educational psychologists from BIA schools with Division of Indian Health programs, collaboration with State and County public health programs, and the use of interested physicians, teachers, or public health nurses to coordinate local programs where social workers, and other more traditional mental health personnel, are not available.

5. The changing identity of the BIA schools as regards to increasing numbers of social and delinquency problems has not been matched by a change in the staff identity, or of the program. For example it seems clear in psychiatric treatment that children with character disorders and delinquency must be treated separately from those who with a psychosis, and again from those who with relative intact personalities. I believe the implication would be that boarding school placement should begin to be specialized. Not only with regard to place and culture of origin, but also with regard to diagnosis and reason for referral, Indian children in boarding schools should insofar as possible be placed in programs geared to their needs. The needs will be different for a delinquent group of children who may need more structure and limit setting, from those who come from Alaska due to distance from available schools. I would like to suggest insofar as possible a geographic distribution system in which children from a given area tend to go to a given boarding school, and to be housed in specific dormitories in that school. This system, which has been adopted in increasing numbers of State hospitals, affords better communication both ways with a smaller number of people involved in the communication. It allows continuity of relationships with parents, teachers, and among the students themselves. It cuts down on the language problem and other forms of culture shock.

6. Needed as a resource for self-esteem and individualization is a resource for an allowance system for boarding school children, as well as an opportunity to earn money for clothes and other means of developing their individuality.

7. In general I felt that mental health energies invested in the school problems would be quickly dissipated unless there was greater evidence of receptivity and awareness of need on the part of school staffs. Rather I felt that supervision and consultation to the medical, nursing, and social work staffs already involved with these schools would be a better approach. It is obvious that communications needed to be maximized, that more contact with the children and the dormitory personnel director would be worthwhile, and that communications about the whole problem of who takes what responsibilities could be helpful. However, in general I felt that in spite of the obvious needs and opportunities, a focus of new mental health activities on the local community level would bring more tangible results.

8. Mental retardation programs and problems may be a crossroads for Division of Indian Health-Bureau of Indian Affairs communications, which may utilize State and Federal resources as well. There may well be an advantage in having a special person or group be up to date in this area, especially where the boarding school populations are large.

9. The question of the incidence, and utilization, of medicine men among Indians residing in Oklahoma is unclear to me at this time. If such people and utilization can be identified, it is obvious that contact with them may well teach us all something of value.

10. Continuing broad generalizations regarding boarding schools, it seemed to me that in general, primary school age children would be better off remaining at home rather than being sent to boarding schools, even if this interfered somewhat with their education, whereas high school age children may well need to be sent off for the intellectual stimulation. At the same time, language, local culture, and family values should be upheld. There need to be expansions of preparation and referral communications at both ends of the community-to-boarding-school routes. Especially to be avoided from the mental health angle are sudden shifts of children from one to the other, without advance planning and communication at the other end.

11. In addition to special reform kinds of institutions for those who are delinquent, a specialized ward for pregnant girls may be very helpful regarding information on feeding, on child development and mental health, and for mutual support. Continued education for this group is especially needed, and is lost under the current ostracizing approach.

12. There is need to increase the utilization of some currently available resources: facilities, such as Claremont, can increase their utilization of a part-time clinical psychologist, and psychiatric diagnostic visits; a resource such as the Lawton Army Base can be used on a contract basis to purchase treatment and consultation services for referred patients and staff; we have already mentioned use of the University and Central State Hospital resources.

13. Increased practical utilization of the area level pharmacy officer should be encouraged. Flexibility of available items in the mental health formulary should be the rule. For example, injectable Librium should be available. The pharmacy officer could render a great service by providing field medical officers with up to date information on dosage levels and utilization of medications for emergencies, such as in alcoholic complications. There is need for the availability of adequate drug doses for sufficient lengths of time for medications in the mental health field. For example, it has been well shown that many patients need to be maintained on phenothiazines for life, and antidepressants such as Imipramine need to be maintained for at least 3 months of adequate dosage in order to prevent premature recurrences of the illness. A brief look at the formulary indicates to me a need for having Stelazine in its various forms available, as it is a standard drug often needed as an adjunct to other medications. I personally believe Sparine in injectable forms might be dropped; and I personally believe that placebo is not a therapeutic drug to be listed in this section of the formulary, although it may well need to be available. I cannot remember whether Paraldehyde was on the formulary available to field personnel.

14. There is a need for a permanent "mental health packet" on file at each field health station, not just in the hands of the service unit director. It might be a function of the area office, perhaps the area level social worker, to supply such an up to date packet at yearly intervals to each facility. Included in such mental health packets might well be the available "expediters", commitment procedures, local variations on State customs regarding handling of emergencies, relationships with courts and sheriffs, and similar, often knotty, problems.

15. There is a need at local levels for BIA-DIH joint meetings, often perhaps including county public health people and public welfare people. The BIA social worker may well be an

under-used mental health resource, as he or she often spends much time arranging for welfare services which may be managed on a routine basis by less well trained personnel.

16. It should perhaps be the function of the area level mental health coordinator to set up for field personnel the in-service education, to provide resource information and emergency referral consultation, and to strengthen the contacts with State and private contract personnel.

17. One important aspect of having information collected at the area office level, is feed back to local service units regarding not only what is relevant for their own unit and how it compares with others within the area, but also what is being done elsewhere in the Division, as well as in the profession.

18. The statistics on patients admitted to PHS Indian hospitals in the Oklahoma area in fiscal year 1967 are interesting, and reflect the probable facts that psychoses and character disorders are being managed in general without admission either to general hospitals or State psychiatric facilities. We do not know the breakdown of diagnoses of those admitted, or readmitted, to State facilities. The Indian deaths listed for calendar year 1966 would be even more useful if compared with data from other Indian, and non-Indian populations, as well as if converted to a rate per population basis. In general these statistics reflect attention to the younger age group in this, as in other areas, for treatment purposes.

19. I would suggest that the annual Indian Community Mental Health meetings include a larger proportion of Indian community members when held next year, and that they focus on the training and supervision of Indian mental health workers.

RESEARCH

An ongoing evaluation should be integral to the program, and should be supported by available resources of all kinds. Useful statistics, the experience of other programs, and the utilization of tools such as those developed at Pine Ridge Reservation, should be available to the field stations and local boards.

1. Among a number of important research projects might be a survey of obesity and its complications, as well as a comparison of the problem and its complications with, for example, urban ghetto populations.

2. Alcoholism research and treatment has a number of obvious needs and advantages. Studies of the actual prevalence of disability at various stages of this disease to assess needs, to evaluate the treatment results, and to determine the worth of treatment approaches such as Antabuse, vocational rehabilitation, and group therapy are indicated.

3. The incidence of suicide, and the related incidence of accidents and homicidal acts, is of enough interest and importance that it is worth evaluating in Oklahoma for the Indian population. The interest of tribal leaders in this area was high, and it seems that a program of reporting on a standardized form such as has been developed at the Pine Ridge Reservation would be a useful way of collecting such information. If this form were adopted at all field stations and routinely sent to the psychiatric consultant or to the area office, we would soon build up a useful baseline level against which to measure future interventions.

4. A further research project, to gain perspective, would be to ask what happens to graduates of BIA schools? How do they compare with public school graduates in Oklahoma? How do Indian students compare with non-Indians?

5. Meaningful research would have to have the backing of the local boards of mental health, since for example, decisions on having a control group to compare with a treated experimental group would depend on positive public opinion. Long-term follow-ups to determine outcome would require a public image which would allow results to be obtained over a period of time.

6. Regarding alcoholism studies: I would like to enlist the aid of the statistics branch as well as the State facilities in identifying where alcoholics live, and obtaining data on death rates, incidence of cirrhosis of the liver, and arrest and accident rates. One hypothesis to be tested would be that the identified, visible alcoholic does not live within his own community, but has already been extruded from it.

7. One of the important contributions to be made by a mental health research program would be to determine the flow of mental patients, the follow-up of interventions made, the sources from which patients come, and the means by which they have been managed in their own communities in the past. It is important to determine how many Indians are present in State programs of various kinds, but it is quite clear that these are only the top of an iceberg.

8. The establishment of a position of research assistant, full-time, for mental health programming, should be set up at the area level unless it is to be set up on a division wide level, for the purpose of helping develop and evaluate research programs which will be of help to the field health stations, for example on alcohol, suicide, mental retardation, and similar problems.

9. Research programs may well deserve a separate budget at the area level. Especially relevant, it seems to me, are the analogies with mental health issues in the ghettos, not only with Negro populations. Just as relevant are the current growing interests in mental health interventions for rural populations, of which the Indian population is an example which in spite of wide geographic distribution has the possibility of bringing to bear a significant amount of professional investment, if research activities can be coordinated division-wide. The research possibilities are especially enhanced by increased availability of case finding, and of follow-up due to decreased mobility and greater utilization of governmental facilities over time.

TRAINING

The entire mental health program should be based on training, with utilization of consultation, teaching, and workshops as the early tools of imparting information.

1. Especially relevant to the training needs of field staff seems to be consultation for medical, social work, and nursing staffs, and an opportunity for mutual exchange and training with the guidance teachers at the boarding schools.

2. Relevant to the mental health training needs of nursing staffs and public health nurses is a focus on help with supportive care. Thus, a workshop on brief treatment methods

emphasizing crisis intervention, environmental manipulation, and the assets and liabilities of hospitalization would be a useful adjunct for selected field staff.

3. Of importance to field medical personnel might be a one-day workshop on drug therapy, covering specifically the uses of sedatives, tranquilizers, and antidepressants, both in the emergency and for the long-term ambulatory patient.

4. One major recommendation I would make would be that the Division of Indian Health set up a means to standardize and provide the training of mental health aides who, it seems likely, will be hired in all areas to help with mental health programs. It would seem far preferable to have a committee set up a core program of readings, supervision, and practical experience, and that one facility be designated as a training center for such groups on a trial basis. Although it is clear that local capacities and needs will vary, it seems self-evident that each facility should not expect to set up a training program de novo for increasingly responsible and yet untrained individuals. The local head of the mental health program will be responsible for the supervision and in-service training of these workers, but they should get a "core curriculum" in a fashion analogous to that of the Community Health Representatives.

5. One advantage of having mental health workers trained according to division wide guidelines would be that this can help resolve some of the professional rivalries, and make GS ratings, which currently range from a 3 to a 7 for such workers, more uniform.

6. Recent figures quoted on median ages of Indian populations, indicating that the median age may be as low as 16, have implications for aiming programs at the lower age groups, at early identification of potential patients, at training people in the aspects of adolescent psychology, and educating parents and teachers in child development.

7. Courses in mental health issues for instructional aides are already being set up in many areas, and may begin to serve as a model for the curriculum for mental health workers who will be in the field.

8. In the Oklahoma area it seems that the public health nurses may actually be the main mental health resources. They need further training in the recognition of and treatment of mental health problems, analogous to what the State public health nurses apparently get.

CONCLUSION

The Oklahoma area health programs differ in two major respects from those in the rest of the Division of Indian Health. For one thing, a diversity of tribes is interspersed throughout the population without a reservation system. Identity as an Indian leads to varying degrees of pride, separateness, and organization as a minority group with leadership. For another, the boarding schools, which apparently have a 4,000 to 5,000 population, take their clientele largely from out of state, without geographic distribution.

Although at present there is no mental health program as such in the area, there are a number of resources, within the Division of Indian Health, within BIA, and within the State and Federal programs. The main strengths for a mental health program for the Oklahoma Indian population include (1) The interest of tribal leaders in having such a program. Their interest in prevention and early identification, as well as in treatment, was impressive. (2) The current expansion of State programs, although it is developing apart from Indian concerns, nonetheless points the way towards future integration of planning and provision of services. For the present, it is clear that separate programs must be set up, communications and public relations maintained, and dovetailing postponed for the future. And, (3) The high level of interest of the IHAD in the mental health of the beneficiary population, in the participation of the beneficiary population and in communications with his own staff.

My current plans, in addition to what has been outlined above, include regular visits to Oklahoma. I will bring a psychiatric resident with me whenever feasible, and appreciate your willingness to cooperate in this regard. I am planning to participate in the Alcoholism Workshop in Clinton in September, as well as to visit the Talihina staff to explore the setting up of an inpatient facility there.

Our explorations with the University of Oklahoma Department of Psychiatry will continue, and while these are unlikely to provide service resources, they will enhance substantially the pool of teaching resources. Clearly the University's plans regarding human ecology and alcoholism are two examples of mutually beneficial ventures.

Throughout the foregoing, an educative approach to staff and clients is evident. There are two features which will need repeated and specific reinforcement: the participation of the Indian community in planning, and the hiring of nonprofessional Indian mental health workers.

The problems which will impede progress, as they do in any new program, include resistance to change within the State, its University, and its population as well as within DIH and BIA staff; the same resistance is present within the Indian population itself, and includes the well-known prejudices regarding mental illness.

The concern for separate facilities is understandable, probably necessary for the present, and to be encouraged when backed by available resources and by the local boards of mental health. All concerned should however be aware that the day will come in the future when the country, and the State, as a whole, as well as the BIA and the Division of Indian Health, will need to hand a greater share of responsibility to the local community as a whole, and to distribute funds according to larger priority needs rather than for special beneficiary groups. That day is, I am convinced, a generation off.

It remains for us, as has been said in many places, to light a candle rather than to curse the darkness. Thank you for giving me the opportunity to make a start. I will maintain contact with you, and follow our progress with interest.

George G. Meyer MD

George G. Meyer, M.D.
Psychiatric Consultant"

D. First Psychiatric Staff - Robert Gordon, M.D.

Robert Gordon, M.D., was assigned to the Oklahoma City Area Office to implement Dr. Meyer's recommendations. Dr. Gordon had completed some psychiatric training and was to have been supervised by Dr. Meyer from a distance. Dr. Meyer had accepted a position at this time in San Antonio, Texas, but remained continually active as a consultant to Dr. Gordon and was available twenty-four hours a day for telephone conferences and backup. However, he was seldom able to spend periods of time on the spot in Oklahoma.

The IHAD at that time, Dr. Jack Robertson, was a person with considerable background in Oklahoma Indian politics, and was anxious that the new Mental Health Program have maximum tribal support. He had a vision of Mental Health Programs as community oriented, tribally powered, and succintly preventive as well as clinically oriented. In this he was at times in tension with IHS staff, most of whom saw psychiatric resources as a scarce commodity, and who needed help with crises and clinical treatment within their hospitals and health centers. Dr. Gordon attempted to meet both needs, spending his time on a circuit not unlike an early itinerant pastor, visiting tribal business committees, meeting informally with as many of the power structures of each tribe as possible, and presenting informative talks at social and ceremonial gatherings. In addition he tried to establish clinical services and to carry out an educational and didactic program within the IHS Service Units to improve the level of care actually being delivered to acute and chronic psychiatric cases.

The two reports which follow, dated six and ten months after he had effectively been introduced into the system, describe Dr. Gordon's activities in almost understated terms. The number of travel hours, and of late evening community conferences, as well as the regular and crisis consultations to all Service Units cannot be adequately described short of a diary. However, these reports do give the picture of accomplishment and the flavor of the developing programs.

"MENTAL HEALTH BRANCH PROGRESS REPORT

Robert P. Gordon, M. D., Chief

March 1970

Oklahoma City Area Indian Health Service
Old Post Office and Court House Building
Oklahoma City, Oklahoma 73102

INTRODUCTION

In many ways Oklahoma has the most complex Indian population of any State. There are over 30 major tribes each with a unique history and culture. There are no reservations. Those identifying themselves as Indian range from people with small amounts of Indian blood who are completely assimilated into the non-Indian world to full-blood Indians who live in rural settings and speak no English. This diversity makes even simple problems such as determining the Indian population of the State extremely difficult. Official figures from the 1960 census say that there are 64,000 Indians in the State but many think the true population is 150-200,000 if all those who identify themselves as Indians are counted.

Even with this great diversity one fact stands out. In spite of the fact that Oklahoma has many successful and influential Indians, the Indian population as a whole has little power, less education and much less money than the non-Indian population.

THE PROGRAM TO DATE

Within this setting the mental health branch of the Oklahoma City Area came into being in July, 1969, with a staff of one full-time person. Prior to this the mental health program had consisted of periodic consultations that helped to develop the framework for the present program.

With a limited staff and an immense task at hand, it was felt that any successful program must be community based. The first priority was to develop interest and knowledge about mental health in the Indian community. The goal was to develop a program that was run by Indians with technical assistance coming from the staff of the mental health branch. At the same time, other program demands were recognized. These included the tremendous need of the hospitals for help with direct patient care and the importance of developing a good working relationship between the hospital staff and the mental health branch.

With these objectives and problems in mind, the branch chief began meeting with Indian groups and visiting Service Units on a regular basis. After eight months the following has been accomplished:

a. Communication has been established with the Indian community through meetings with tribal councils, tribal health committees, community groups, and local leaders. In all these meetings, the philosophy of Indian control has been stressed and the necessity for involvement at the local level emphasized. Such meetings have given the branch chief an opportunity to learn firsthand about the problems as seen by the community and hopefully will serve as bases for cooperative efforts between the branch and local citizens.

b. A regular clinical program has been started at most Service Units. Patients are seen for both therapy and evaluation.

c. Emergency telephone consultation is available 24 hours a day.

d. A solid consulting relationship has been established between the mental health branch and most Service Units. Patient management, help with personal problems of employees, personnel difficulties, and institutional communication problems have been among the subjects for consultation. These consultations have been with both professional and non-professional employees in group and individual sessions. The branch chief is always available to help hospital departments with any mental health problem that may arise.

e. Contacts have been made with many groups including the State Mental Health Department, University of Oklahoma Department of Psychiatry, Central State Hospital and Tulsa Psychiatric Foundation, in order to orient these agencies to Indian problems in the State and explore ways that they might work with Indian Health.

f. The branch chief has had a chance to thoroughly orient himself to Oklahoma and the unique problems of the Indian community.

NEW PROGRAM DIRECTIONS

The program is now entering a new phase with greater emphasis on community involvement. This aspect of the program may be broken into three parts.

Intra-community organization is the first of the three. An example of such an effort might be a network of volunteers with some mental health training who deal with personal crises. Another might be a group that runs an educational program dealing with alcoholism or delinquency. These projects woul be entirely within the Indian community.

The second part focuses on making public agencies more responsive to Indian needs. Because there are no reservations in the State, Indians use many of the same services as the non-Indian population. These include public schools, welfare, State hospitals, etc. Unfortunately, the Indian has little voice in the running of many of these institutions. Public school systems are good examples. There are few Indians on school boards throughout the State and in most cases the Indian parent feels that his wishes count for little. Consequently, one often sees disinterest on the part of the parent which is then reflected in the child. A first step to do something about this problem has been undertaken in the southeastern part of the State. As a result of two mental health meetings five committees have been started that will try to set up regular communication between the Indians and the local schools. Hopefully, this will lead to increased Indian participation in the school system.

It has been shown that services that are planned without involving Indians will be used little by them. This is not because they have no need of the services. Rather it is because there has been little communication between the providers of the service and the Indians. Consequently these services have often not suited Indian needs and have not been accepted by them.

At this point, one of the most important developments in mental health is the ever expanding network of comprehensive community mental health centers. At present in Oklahoma such centers are functioning in Norman and Ponca City. One is about to start in Tulsa and final plans are being made for one in McAlester. Since the chances are that the Federal government will channel much of its direct care mental health money to these centers it is crucial for the Indian community to become involved in the planning and operation of these centers. Unless this is done few Indians will use the facility. Facilitating this contact between these centers and the Indians in the State will be a high priority project. In the Lawton area, an ad hoc committee has been formed to start such a center. At the initial meetings the branch chief and Service Unit Director have stressed the necessity for bringing the Indian community into all phases of the project.

The third part of community participation concerns the resources of the mental health branch itself. As additional staff is added to the program important decisions about the kinds and priorities of program will have to be made. These must be made by the Indians. Therefore, it is imperative that tribal groups begin to think about mental health issues and go over possible apprcaches.

The implementation of these three phases of community participation is a difficult but crucial task. Regular liason must be established between the branch and all tribal health committees. Hopefully, one person on each committee will take a special interest in mental health and work closely with the branch chief. Community meetings will be extremely important. The health educator at each Service Unit will have major responsibility for setting up these meetings and will take on the role of field mental health coordinator. Community Health Representatives will also be looked to for assistance. A tentative plan might involve having a first meeting at the hospital with leaders from several different communities. This would be followed by general mental health meetings in the various communities where the proglem as seen by the community would be discussed. If there were particular interest in one topic such as school drop-outs a follow-up meeting or workshop dealing with just this one subject would be held. A special meeting on school dropouts with those individuals working on the five committees in southeastern Oklahoma will be held next month in the Broken Bow area.

Hopefully, a meeting such as the one outlined above will mobilize interest and action in such vital areas as school drop-outs, delinquency and alcoholism.

Even though community out reach activities will be emphasized in the coming years, the hospital based part of the program will remain vitally important. Regular clinics will continue to be held at most Service Units and the branch staff will be available for consultation on any problem.

A very successful program involving meeting with different employee groups in the hospital has been started at Talihina and will be expanded to other Service Units in the next year. In these meetings, the branch chief has met with Registered Nurses, licensed practical nurses, aides, maintenance and laundry personnel. These sessions introduce the mental health program to the employees and emphasize the individuals' identification as a health employee rather than in a specific job category. They provide information about mental health in general and specific assistance is given with patient care problems. People ventilate their feelings and the importance of the psychological aspect of every job is emphasized. Since most of these people come from the local community these meetings provide another avenue for communication between the branch and the Indian people.

A problem that continues to exist is fragmentation of mental health services. In any one Service Unit such diverse groups as welfare agencies, health departments, State hospital follow-up clinics, child guidance clinics, Indian education workers as well as Indian Health Service and Bureau of Indian Affairs concern themselves with many common problems. One of the goals for the branch in the next few months will be to arrange a mental health coordination meeting at each Service Unit involving these various groups. At such a meeting, each participant could become familiar with these other programs and coordinated rather than parallel efforts should result. Social service, and health education will work with the Service Unit and the mental health branch to arrange these meetings.

Maximum communication and cooperation between the various branches within the Indian Health Service is perhaps even more important than coordination with outside agencies. In the first months of the program, mental health has worked most closely with social service and health education. However, since mental health problems involve all disciplines it is hoped that all branches will feel free to consult the mental health about any area where its skills and knowledge would prove helpf[illegible] Perhaps as the branch gains more staff a regular meeting in the Area Office that focuses on mental health problems could be started.

In any large organization, communication barriers tend to arise, Since opening channels of communication at all levels is a primary concern of the mental health program, it is hoped that the branch will not only encourage maximum interchange at the Area Office level but between the Service Units and Area Office as well. As an Area level branch that works primarily in the field the mental health team will be in an excellent position to maximize flow of information between the field and Headquarters.

The Service Units in North Carolina, Mississippi and Florida pose special problems due to their distance from the Area Office. If possible local arrangements for direct services must be made. The Cherokee Service Unit is now developing such a program. In spite of the direct service limitation, certain things can still be accomplished. Each Service Unit should have a mental health coordination meeting as mentioned earlier. Since these States have small Indian populations outside agencies tend to have less familiarity with Indian problems than is the case in Oklahoma. Therefore, a prime goal of such a meeting should be to orient these agencies to Indian problems and encourage close cooperation with Indian Health. In addition to these meetings, the branch chief could meet with hospital staff and Community Health Representatives to discuss mental health and provide consultation about on going problems.

As the various programs that have been outlined above get started, more manpower will be essential. At this point, there are plans to add two full-time people to the team in FY 1971. One will be either a social worker or psychologist and the other will primarily concern himself with community coordination. The addition of these two people will allow a program to be developed at every Service Unit. A closer consulting relationship with staff at the Bureau of Indian Affairs schools will also be to start.

With such developments at the local level it will be necessary to have someone at each Service Unit who can function as a full-time mental health person. Ideally, as funding increases, positions in mental health very similar to Community Health Representatives could be developed. These would involve people from the community who would work for the tribal groups and have special training in mental health. Such people could function in many ways. They could arrange meetings in the community and serve as resource people. They could also deal with both individual and family problems. Though no such positions are anticipated for the coming year, hopefully, they will come into being soon thereafter.

CONCLUSION

Any program that is to achieve success must recognize the importance of Indian involvement and control. To look in any other direction would mean certain failure. The mental health branch recognizes these facts and within such a context hopes to forge ahead in the coming year."

"MENTAL HEALTH BRANCH PROGRESS REPORT

Robert P. Gordon, M. D., Chief
November 1970

Oklahoma City Area Indian Health Service
Old Post Office and Court House Building
Oklahoma City, Oklahoma 73102

INTRODUCTION

This year the Mental Health Branch of the Oklahoma City Area Indian Health Service will be in its third phase of growth. Prior to July 1969 the program consisted of periodic psychiatric consultation and occasional contract services. In July 1969 a full time psychiatric consultant joined the Area and the Mental Health Branch was created. Unfortunately anticipated funding never materialized and the branch remained with one full time person through that year.

However the budget picture has now improved. For the first time specific funds have been earmarked for a mental health program. The Oklahoma City Area was the only program that had been without funds prior to Fiscal Year 1971.

With this increase in funds the branch will be able to expand its staff and services. The concept of Indian control and involvement will continue to be the guiding principle of the branch as it has been in the past.

PROGRAM DIRECTIONS

Past experience has shown that effective mental health programs do their most important work in the community rather than in the hospital setting. A program that can prevent problems from developing will achieve more than a program that deals with end results. The part of a mental health program that is concerned with this kind of effort is called a field or preventive program.

A field program must be based upon active community participation. One of the prime objectives of the Mental Health Branch will be to establish mental health committees in each service unit. These committees will be the base of the preventive program and will serve as a major liaison between the branch and the Indian people. At first the committees will probably help to establish mental health education programs that will bring Indian citizens together to look at problems in their own communities. As local groups explore problems, the mental health committees working closely with the Mental Health Branch will be able to assist in developing projects that attack these problems. An example of such a project might be a series of discussions on school drop-outs followed by the organization of an Indian parents group. In all these projects the Mental Health Branch staff will provide as much technical assistance as they can but the programs will have a much greater chance for success if local citizens take a leadership role.

One important new direction in the Indian Health Service is the increasing emphasis on projects that are run by tribal groups. As the mental health committees develop they can apply for funds to run such projects. Mental Health Branch people will help in developing these grant proposals but the money will go directly to the mental health committee or other Indian groups.

Even though great emphasis will be placed on the preventive program the direct service or clinical part of the program will not be neglected. By early 1971 there should be regular mental health services available at each service unit on a periodic basis. This means that a psychiatrist, psychologist or social worker will see patients for both individual and group treatment. Even though not all those in need of mental health consultation will be seen, this will represent a tremendous step forward.

In addition to the community and clinical program the branch will continue active consultation and in-service training. During the next year the branch will also work closely with Community Health Representatives in order to further develop their mental health skills.

STAFFING FOR FISCAL YEAR 1971

There will be eight full time people in the branch. This will include the branch chief (psychiatrist), deputy branch chief (a mental health professional), a psychologist, a social worker, two mental health workers, a field program coordinator, and a secretary.

The field program coordinator and mental health workers are new kinds of positions and are discussed below.

In order to begin to decentralize the operations of the branch and deliver services more efficiently the psychiatric social worker will have responsibility for program in just the Tahlequah and Claremore Service Units and be based in one of the two. In addition to providing help to these two extremely busy service units the Mental Health Branch will be able to work in the extreme northeastern corner of the State, where there has been little contact in the past.

FIELD PROGRAM COORDINATOR

The field program coordinator position is a new and exciting innovation. It is proposed that this person be an employee of the Area Advisory Board who will work in the Mental Health Branch. The Area Advisory Board will select this individual and he will be paid by the Advirory Board through a contract with Indian Health. Adequate funding for such a position is included in the mental health budget.

This person will have responsibility for insuring that there is maximum Indian involvement in the Mental Health Program. A major part of his job will be to help set up and coordinate the activities of the mental health committees mentioned above. In addition he will act as a liaison between the branch and Indian groups. The contract between Indian Health and the Advisory Board will spell out what this person is expected to accomplish. It will be up to the Advisory Board to decide upon exact duties and qualifications for the job. Some job activities might include organizing meetings within communities, meeting regularly with tribal groups, assisting mental health workers in community projects and general administrative mental health work.

If this proposal is accepted by the Advisory Board, the Mental Health Branch Chief will be available to provide technical assistance in developing the position.

MENTAL HEALTH WORKERS

One of the most important developments in health care in the past few years has been the creation of many para-professional positions. In many instances people from local communities who have been given limited professional training have been able to accomplish tasks that professional people had tried but failed. The principle that is now recognized is the value of knowledge gained by living in a community and being accepted by its people. In the past white middle class professionals had often not been aware of many community needs and problems. The para-professional often has been able to educate professionals about these needs.

This year Indian Mental Health Programs will be adding mental health workers. The Mental Health Branch in the Oklahoma City Area will have two such positions. Each of these will be assigned to an individual service unit. It is hoped that by next fiscal year there will be at least one mental health worker in each service unit.

These workers will serve as a liaison between the local Indian communities and the Mental Health Branch. They will take an active part in the field program and work with the field coordinator in setting up community meetings and developing community projects. They will also assist clinically with case finding, crisis counseling, and aftercare. As their skills develop they will be given greater and greater responsibility.

It is hoped that career development programs for these people will be established. These positions will be at GS-5/6 level. There will be minimal educational requirements but applicants should have demonstrated skill in complex human relationships. He should know the community he serves and be accepted by its members.

This will be a new program. These people will have to be carefully trained and closely supervised in order to develop their skills to a maximum degree. There undoubtedly will be some problems but there will almost certainly be many outstanding innovations. In order that possible problems be minimized these first two workers will be placed in homogeneous service units where adequate professional back-up is provided. Two such service units are Clinton and Tahlequah.

These people will be selected jointly by the Mental Health Branch and tribal health committee. Because of the type of work performed and the close supervision provided it is extremely important that these workers be able to develop a smooth and close working relationship with members of the Mental Health Branch.

FUTURE PLANS

In the next fiscal year several more health workers will be added. As mental health services become firmly established additional professionals will also be needed. Special projects involving screening programs for emotional problems in young children, alcoholism prevention, school drop-outs and possibly expanded in-patient psychiatric capability will be developed in the next few years. Services must also be increased at BIA boarding schools whose population is more and more composed of children with specific problems.

However the key to success in all future projects must be recognized. A program that improves the mental health of the Indian people will only be successful when directed and controlled by them."

E. Central Oklahoma Service Units

1. David Larsen, M.D., and John Bjork, M.S.W.

During the second year (1971-72) of his tour of duty, with his first Mental Health Budget in hand, Dr. Gordon began hiring staff and devoting more energy to planning. Following his own pattern of work, as well as that of other Areas, he conceived of the Branch as having a centralized operation. Even staff not located in Oklahoma City were organized as Area staff and, in the beginning, provided service to more than one service unit location. Four or five Area Office positions were developed as basic to the needs of the program: a chief administrator, deputy, clinical consultant, community organization consultant to tribal groups (contracted for through the Area Board), and a secretary.

The first Area person employed was Liz Ahkeahbo, as Secretary in September 1970. Mrs. Ahkeahbo came from the Tribal Affairs office and brought with her a helpful knowledge of Oklahoma City Area tribes.

John Bjork, M.S.W., was recruited next as Deputy Chief in March 1971. Mr. Bjork had been Co-Director of the NIMH-IHS-BIA sponsored research in boarding schools centered at Flandreau, South Dakota, and later Deputy Chief (Area Mental Health Consultant) of the Aberdeen Area Social Service Branch. The overlap of approximately four months allowed both men to further develop planning for the Branch, which included arranging for the orderly transfer of relationships with staff and tribal leaders, from Dr. Gordon to Mr. Bjork. Upon Dr. Gordon's departure, Mr. Bjork became Acting Chief and, eventually, Chief of the Branch.

David Larson, M.D., joined the staff as Area Psychiatric Consultant in July 1971, following completion of his residency. In September 1971 a contract offered to the Area Board was consummated with the hiring of Paul Stabler, B.S., as Area Mental Health Coordinator.

In January 1971 Calvin Beames became Area Director and was the first person of Indian descent to hold such a position. Among his policies which affected Branch development were those having to do with both decentralization and Indian involvement. The vacant Deputy position was changed to that of a Mental Health Consultant and moved to the field. The Area Psychiatric Consultant position was changed first to two field psychiatric consultant positions for Eastern and Western Oklahoma (Kansas had contract arrangements with Menninger Foundation for consultation until July 1973).

Although his duty station did not change, Dr. Larson was no longer expected to meet the needs of seven service units during his second year. He was able to focus most of his attention on Lawton and Shawnee, providing, in addition, some service to Pawnee and Claremore. Dr. Jorge Ferriz served in eastern Oklahoma as a consultant to Tahlequah, Talihina, and Tishomingo. Dr. Mary Frances Schottstaedt provided weekly consultation to Clinton beginning in the fall of 1970.

At the conclusion of Dr. Larson's tour, Mr. Bjork and he agreed that even the East-West Division could be dispensed with in favor of staffing with other, more readily available disciplines. The recruitment of full time psychiatric staff had deteriorated with the end of the physician draft, and it was thought that adequate consultation could be arranged with psychiatrists in practice in Oklahoma to reach, eventually, all the service units.

In 1969 and 1970 the Area Office IHS Mental Health staff had sought local Indian involvement. However, Mr. Beames came from the Tribal Affairs office and during his tour as IHAD preferred to maintain close relationships with tribal leaders rather than having this function spread among his Branch Chiefs. This stance also affected the Tribal Mental Health Coordinator position in two ways: The contract had to be written as broadly as possible to give the Board as much freedom as possible. There was also a strong mandate that the IHS Mental Health staff not attempt to supervise the Coordinator but allow him to develop a program primarily responsive to the wishes of the Board and Indian people. That concept, as well as federal regulations, also resulted in the Coordinator's not being provided Area office space as originally planned. The Coordinator worked from his home in Tulsa until the Board opened an office in Oklahoma City. At that time the Coordinator came under the supervision of the Executive Director of the Board. The position was further developed in the Spring of 1973 and the title and duties changed to those of Mental Health Educator. The responsibilities of that position are described later in this report (see p. 116).

Mr. Bjork defines his roles as Area Chief of Mental Health Programs as follows:

> "He provides leadership and direction to all aspects of the program. He has basic responsibility for program development decisions through the process of budget preparation and expenditure. He participates in the recruitment, selection, evaluation and career development of staff. He provides technical guidance and direction to Branch staff and consultants and consultation to other Area and Service Unit staff regarding patient care and general program development. He develops working relationships with numerous federal, state, and regional agencies, tribal groups, and voluntary organizations in the mental health and mental-health-related fields."

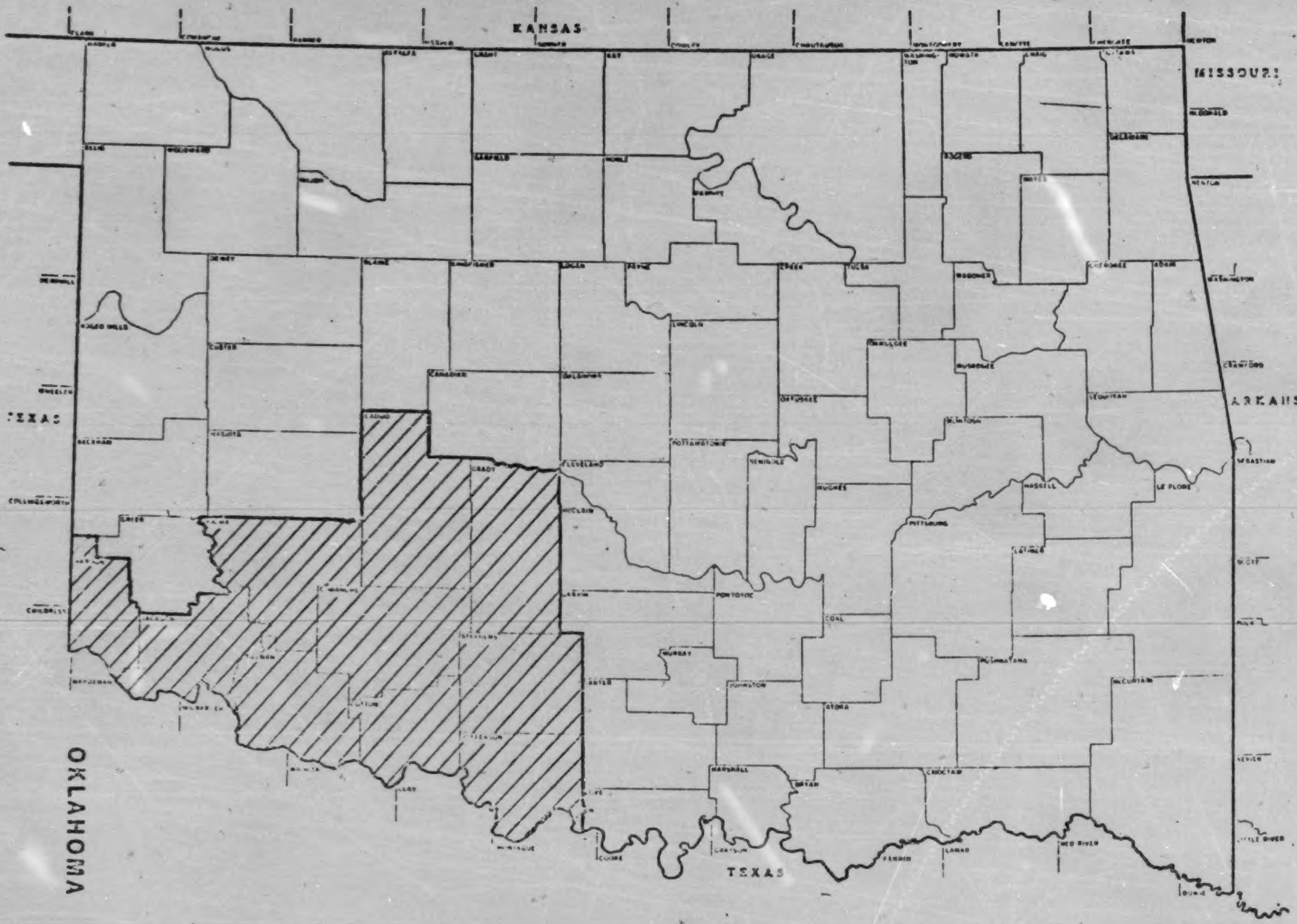
Dr. Larson established a role for Area Psychiatric Consultant which is described by Mr. Bjork as follows:

> "Dr. Larson assumed responsibility for two Service Units throughout his period of employment (Lawton and Shawnee) and for four others (Claremore, Pawnee, Tahlequah, and Talihina) for varying lengths of time. He provided some consultation to the Branch

> Chief regarding the three remaining Service Units and the Area Mental Health program in general. When the two other Area Office physicians were away, he provided general medical consultation to the Area Director. He took full responsibility for the treatment of patients. As a consultant, he understood the need for helping others maximise their contribution to patient care. He undertook training sessions for physicians and nurses in the management of disturbed patients. He accepted one-time speaking engagements with a variety of groups. Near the end of his tour he taught a course for University credit to twenty-eight boarding school dormitory attendants."

Mrs. Ahkeahbo provided more than receptionist and secretarial services from the beginning of her employment in the Area Mental Health Programs office. She has developed a close working relationship with the Area Mental Health and Social Service staff as well as with many other people with whom collaborative relationships have formed. Her personal warmth, keen sense of where resources may be found, and what the status of projects may be at any time adds more than mere secretarial skill to the accuracy and completeness of reports and activities of the Area office.

Lawton Service Unit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2. Lawton

The Lawton Service Unit is across the main highway from the grounds of Fort Sill and adjacent to the Fort Sill Indian School at Lawton, Oklahoma, in the south-central portion of the state. Since it is on a major traffic artery connecting Oklahoma City and Dallas, it receives a fair number of accident victims and travelers who do not reside within the Service Unit. Lawton, a town of 75,000, has a constant military population of at least 30,000 and many of the social problems associated with frontier military installations of such a large size.

There are regular scheduled flights on two commercial airlines, frequent busses, and a Turnpike which connects with Oklahoma City in about an hour and a half drive.

Indian City, U.S.A., near Anadarko, provides steady attraction to tourists, and the pageantry and dances are a part of the recreational life of the Indian groups of the state, particularly those in the western half.

The Lawton Service Unit is a new eighty bed hospital, and health stations are operated in the western communities of Carnegie and Hobart. Two BIA schools, Fort Sill Indian School at Rowlo and Riverside Indian School at Anadarko, are provided health and mental health services.

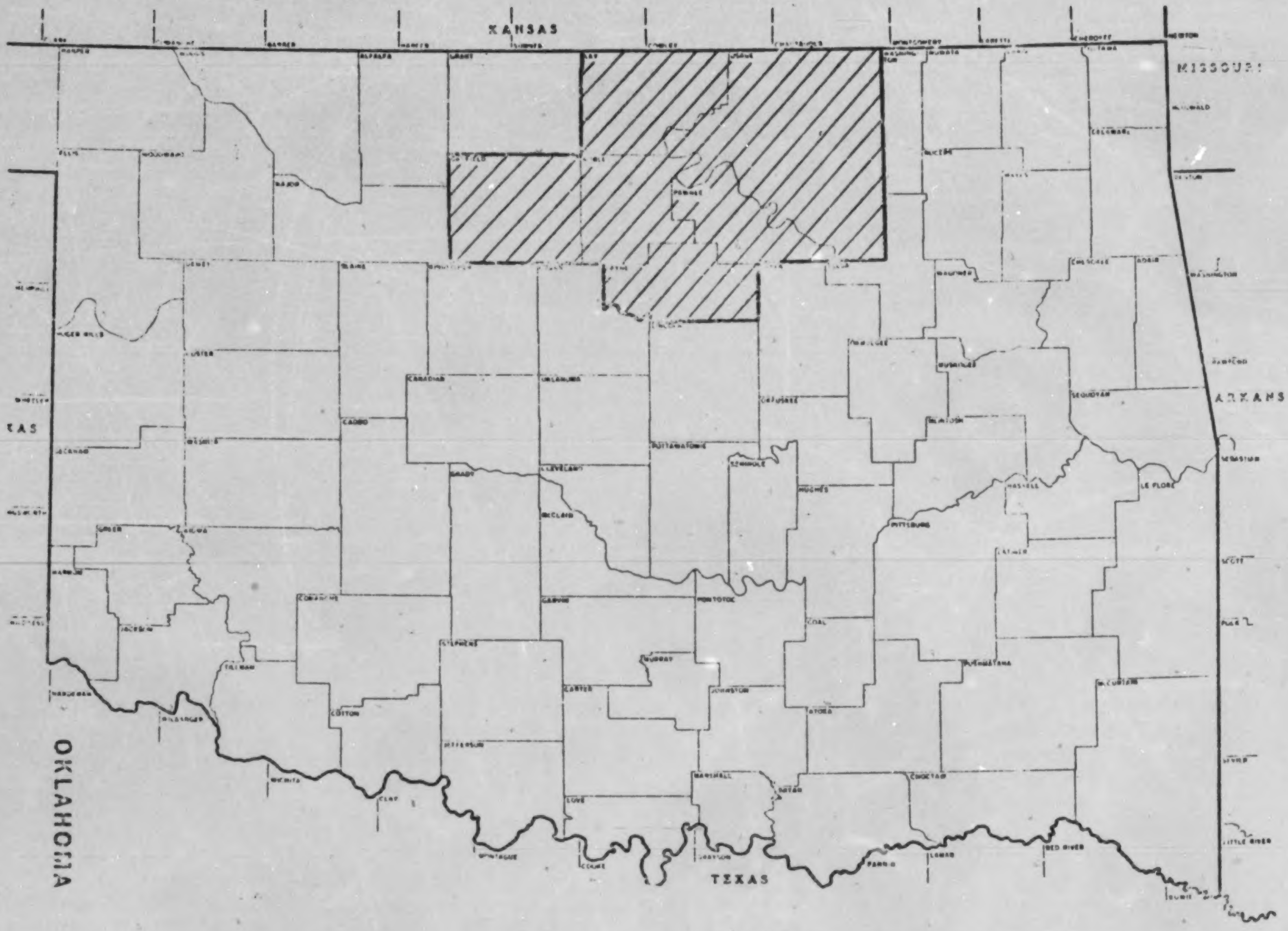
In planning for a permanent staff, it was hoped that part of the older and now unused buildings could be utilized for a day hospital program and for special children's activities. While they were temporarily officed in some of this space, it has been more convenient to move to an unused portion of a pediatric wing in the new hospital. The present staff member Richard Downey, M.S., covered some social service responsibilities while the assigned social worker was away at school for a lengthy period of time.

A special project of the Lawton staff has been group therapy for the problem of weight control. Consultation to staff and to local schools as well as the BIA schools is usually of an educational orientation, around general Mental Health principles and services. The individual patient caseload appears to be about eighty patients, with an estimated two hundred contact visits per quarter. Plans for adding a Mental Health technician have advanced to the stage of advertising and selection from applicants as of the close of the calendar year 74. In general, this mental health program continues the trends established by Dr. Larson and Dr. Gordon, with emphasis on clinical activities. In emergencies backup psychiatric consultation is available through a local psychiatrist.

In his annual report to the IHAD for 1974, Mr. Bjork summarizes the highlights of the Lawton program:

> "In addition to direct patient care, Mr. Downey has been active in providing in-service training about mental health topics to staff and CHR's. He has worked closely with the Fort Sill Indian School staff and interviews patients at the Anadarko Clinic each Friday. He attended the Family Therapy Workshop and a two-week course entitled Community Mental Health Principles in Action for Senior Staff of Human Service Organizations, at Harvard Medical School, in April.
>
> Shortly after joining the Lawton staff, Ms. Gachot enrolled in the Social Work/Psychology Procedures Course, Academy of Health Sciences, Brooke Armu Medical Center, Fort Sam Houston, Texas; she will return to the Service Unit 6-24-74."

Pawnee Service Unit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3. Pawnee

The Pawnee Service Unit is located in the north central area of Oklahoma, about a mile east of the town of Pawnee which has a population of 2,500 people. It is ninety miles from Oklahoma City and about fifty-six miles from Tulsa. The hospital of thirty-two beds is the central facility of the Service Unit, and field health stations are maintained at Pawhuska, White Eagle, and at Chilocco Indian School, which presently has a population of around 650 high school students.

The basic problems of many of the students at the Chilocco School reflected not only the distance from home, but also the fact that the placement at BIA schools was for social reasons (delinquency, inadequate hom situations, or poor school adjustment) as often as it was for lack of available educational facilities. The BIA schools have not as yet developed their curricula and staffing patterns to accomodate this new type of student personnel, which has already been identified in Dr. Meyer's preliminary planning reports. Without being able to change the context of the schools, the student problems referred for mental health consultation could seldom be satisfactorily resolved. The contract was eventually dropped until a more favorable climate could be developed on the campus.

However, in 1973 a new superintendent was appointed at Chilocco, and IHS Mental Health Staff have been able to work with a small group of glue sniffers, and to consult with the Alcohol Education and Recovery Director, as well as seeing pupils for individual sessions in the health clinic on the grounds..

The Mental Health staff presently consists of a psychologist, Donald Sampson, Ed.D., a Mental Health Specialist, Lavina Wichita, LPN, and a Mental Health Technician, Wilson F. Moore. Miss Wichita is one of the new style paraprofessionals who received training at Fort Sam Houstonunder a rare program of collaboration between federal agencies, initiated by Mr. Bjork. This training and experiences with the services of Dr. Larson have sensitized the staff to appreciate psychiatric consultation without rendering them impotent or dependent.

This team is actively involved in both program planning and consultation around invidivual children in the Headstart programs in Pawnee, Osage and Creek counties. The Mental Health Technician is particularly active in developing a joint mental health program with the prenatal clinics held for teenage unwed girls. The staff as a whole are all in active relationship to the Alcoholism Counselors and facilitate the use of Indian Halfway Houses in other parts of the state since none is available in their Service Unit. Liaison with Legal Aide services has also been developed for appropriate cases. The nearby State University at Stillwater has an Indian counselor who works with the staff and calls upon them for emergencies involving Indian students. Several public schools with sizable Indian enrollments are also utilizing regular consultation.

The largest gains reported, however, are the increasing number of referrals from IHS physicians and staff in the hospital and outpatient center itself. Hospital visits average around two thirds of all individual patients seen, with the number of patient contacts in any one month being between thirty and fifty.

In the Area Annual report for 1973-1974 the Pawnee Mental Health Program is described as follows:

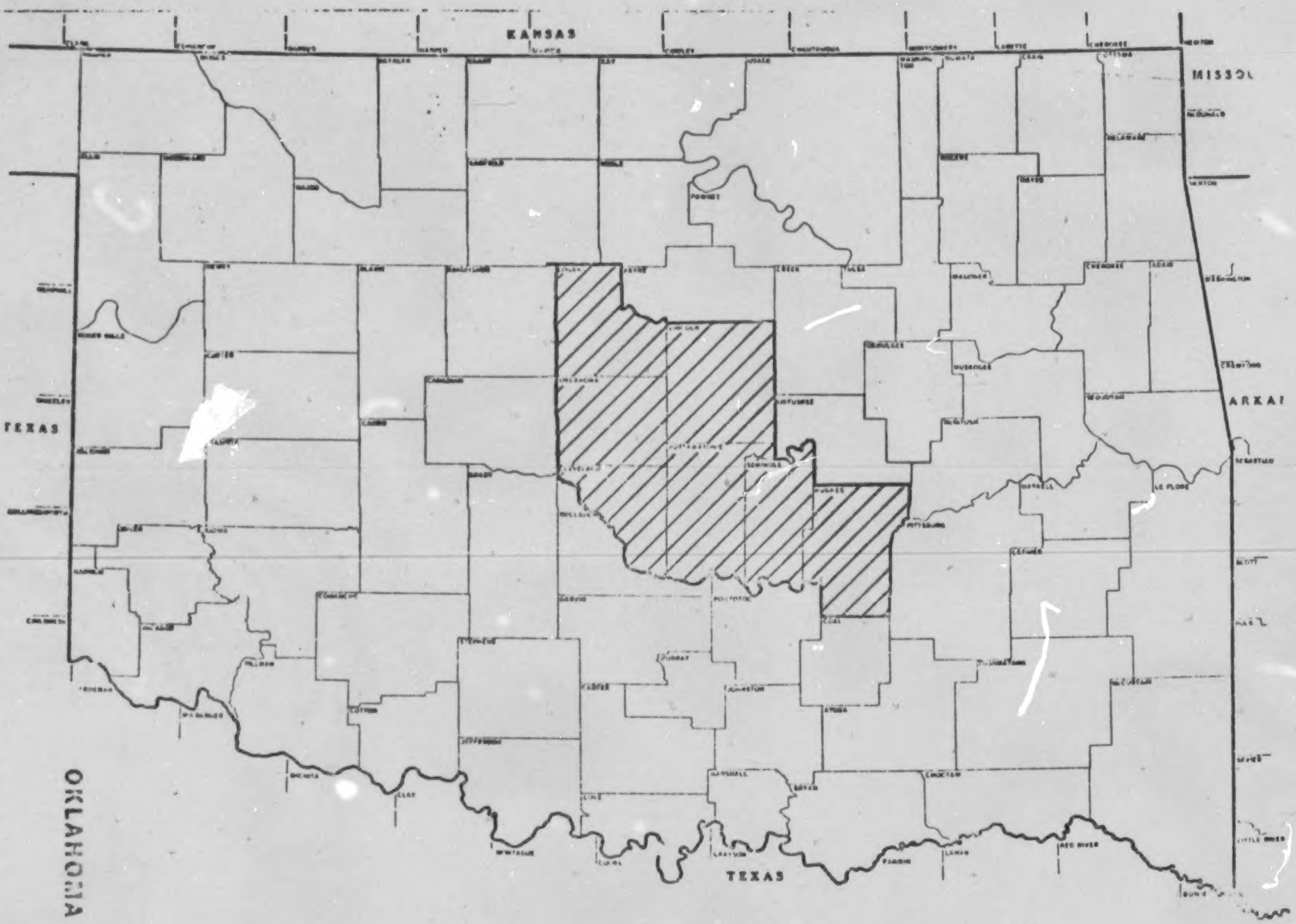
> "In addition to direct patient care, Dr. Samson provides treatment to Chilocco students, individually or in groups, on a weekly basis. He provides direct services and consultation to public schools and Headstart programs. He also provides patient and program consultation to the Indian Recovery Program and the

Alcohol Education and Recovery Program at Chilocco. He is Chairman of the Pawnee Community Resources Committee.

Ms. Wichita provides direct patient care. She has also been actively involved in a wide variety of community services, including work with the CHR's, the Johnson O'Malley program, the Title IV Committee on Education, as a sponsor of the Pawnee High School Indian Club, and as Chairman of the Indian Parent Education Committee. She completed the Fort Sam Houston Training this year and attended Family Therapy Workshop.

Mr. Moore began as Secretary to the Pawnee Branch but was promoted to Mental Health Technician during the year. Mr. Moore provides direct patient care and he also participates with Dr. Samson and Ms. Wichita in work with various committees. He was successful in helping a CHR locate playground equipment and he is currently working with an Indian Methodist Minister to locate housing for a teen center."

Shawnee Service Unit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4. Shawnee

Shawnee originally was a tuberculosis sanitorium located about forty miles from Oklahoma City in central Oklahoma. As the need for a large number of beds for TB patients declined, the buildings and grounds were returned to the tribes who had donated the land, and only an outpatient Health Center is still operated at Shawnee with Field Health Stations at Wevoka and Wetumka open on a part time schedule. Patients needing hospitalization are sent to one of the other IHS hospitals or cared for locally under contract care arrangements. There are seven tribes who utilize the Shawnee Service Unit, together with any residents of Oklahoma City who find it the closest IHS facility and who have difficulty utilizing city resources. A recently established Oklahoma City Urban Health Project seeks to alleviate this particular portion of the stress upon both city residents and the Shawnee facility.

From time to time in the past the public health nurses, social workers, and physicians have developed excellent rapport with local mental health resources, but as personnel changes occur, both in IHS and locally, these links tend to be lost and need to be re-established. Dr. Larsen concentrated on seeing individual patients, mainly adults, and consulting with IHS staff.

When Dr. Larsen left Oklahoma, Dr. Mary Frances Schottsteadt* of Oklahoma City added a regular monthly visit to Shawnee to her schedule of IHS consultations for 1973-1974, and a Mental Health Technician position is being added with training at Fort Sam Houston arranged for the summer of 1974. In the absence of other full-time Mental Health staff, the technician will be supervised by the Shawnee Service Unit Social Worker, Ms. Gergene Hale.

Dr. Schottsteadt's report summarizing her first year's work in Shawnee is quoted in full since it contains both detail and thoughtful comments.

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* In the summer of 74 Dr. Schottsteadt moved to Houston, Texas and is no longer available to IHS.

Shawnee Service Unit, Indian Health Service
Annual Report, Psychiatric Consultation Service
September 1, 1973 to June 15, 1974

Introduction

The Shawnee Service Unit has had regular psychiatric consultation services available for approximately three years. Dr. David Larsen, IHS psychiatrist visited the clinic from 1971 to 1973. The Department of Psychiatry and Behavioral Sciences, Oklahoma University College of Medicine has furnished a psychiatrist on a contract basis since September 1973.

The Shawnee clinic is an out-patient service only, providing care to a population of about 18,000 in seven counties in central Oklahoma (Pottawatomie, Seminole, Oklahoma, Cleveland, Logan, Lincoln and Hughes). Hospitalization when needed is provided by other IHS facilities or by contract arrangements. The tribes served by the Shawnee Service Unit include Shawnee, Pottawatomie, Sac & Fox, Iowa, Kickapoo, Seminole and Creek, all of whom had land allotments in the area. Because of proximity to Tinker AFB & metropolitan Oklahoma City a number of other tribes are also represented making this a diverse and fascinating population to work with. It ranges from the Pottawatomies, in whom inter-marriage over generations has resulted in considerable assimilation, to the Kickapoos who continue to live in isolated communities, making annual pilgrimages to Mexico and avoiding contact with the surrounding white society.

Though the Shawnee Service Unit has out-patient clinics in several smaller communities all psychiatric work was carried out at the Shawnee Clinic. Key professional personnel included Mrs. Georgene Hale, social worker, and the three physicians, Drs. Allan Metz, Robert Englund and Murray Caplan. Mrs. Hale took responsibility for keeping the list of patients referred for psychiatric evaluation and setting up appointments. She often interviewed patients and family members first, providing written as well as verbal information which was most helpful. Psychiatric summaries were mailed to her. She shared them faithfully with the physicians in charge. Unless there was a specific contraindication the summaries were filed in the medical records where they would be readily available to future physicians furnishing medical care. Mrs. Hale also took the responsibility for making referrals for further work-up and therapy unless these referrals were to the Department of Psychiatry & Behavioral Science. In this case it was simpler for me to make the necessary arrangements. Mrs. Hale was great to work with throughout the year. She was always cooperative, efficient and concerned about the welfare of the patients.

Direct Patient Services

Bimonthly trips were made to Shawnee Clinic on the following dates:

September 7, 25, 1973
October 9, 20, 1973
November 13, 27, 1973
December 11, 1973
January 8, 22, 1974
February 5, 19, 1974
March 5, 19, 1974
April 2, 30, 1974
May 14, 28, 1974
June 11, 1974

Forty-five patients were seen for a total of 81 interviews, one of these being seen in a group meeting only. Eight family members were also interviewed. The average number of interviews per day was 4.8. The distribution of interviews was in keeping with the guidelines of IHS Mental Health Branch, namely that psychiatric consultation time be concentrated on evaluations and very limited brief therapy.

Number of Interviews	Number of Patients
1	24
2	12
3	4
4	2
5	2
6	0
7	1

The age of patients seen at Shawnee is as follows:

Years	Number of Patients
0-9	1
10-19	9
20-29	9
30-39	13
40-49	6
50-59	5
60-69	2

The distribution of patients seen by broad diagnostic category is as follows:

Diagnostic Category		Number of Patients
Acute and chronic brain syndrome		2
Psychoses and borderline states		14
Personality disorders		3
Psychoneuroses		21
Anxiety	5	
Depression	16	
Behavioral problems		1
Situational reactions		4

As is usual with psychiatric populations it is difficult to attach just one diagnosis to a patient, since so many have multiple and overlapping conditions. In the above table the most prominent or presenting problem has been listed. Once again the prevalence of depression in a population seeking medical care needs emphasis. Four patients had a history of suicide attempts, 3 had multiple and severe physical symptoms. Only two gave a history of chronic alcoholism, 14 were borderline or chronic psychotic patients, 9 being schizophrenic and one probably a manic-depressive. Further information on patients seen will be found in the appendix.

Because of the number of chronic psychotic or borderline patients a therapy group was started at Shawnee. The intention was to learn to know these patients better by seeing them regularly, to help them with socialization since many were quite withdrawn, to regulate their medication more efficiently, and to provide them with sufficient support so that drug dosages might be reduced. Mrs. Hale & Al Matilla, a pharmacist, were co-therapists, enabling them also to learn to know these patients better so that our follow-up care could be maximally efficient and effective. The group met on the following dates:

Dates	# Patients
Mar 19, 1974	4
April 2, 1974	3
April 30, 1974	4
May 14, 1974	2
May 28, 1974	3
June 11, 1974	5

The group was initially conceived as a socialization group, but became more of a psychotherapy type, since the patients attending were sufficiently integrated and interested in working on specific problems. Though the group has met only six times an esprit has developed and the patients are offering help and suggestions to each other. The June 11th meeting was spent exploring the old Sacred Heart Abbey ruins and sharing a picnic lunch. Two of the patients and numerous family members had attended school there in the decades from the 1880's to the 1940's. The trip was a unique experience for all of us. For follow-up of some patients seen for evaluation this group has been a valuable resource. These patients are used to coming to the Indian Hospital and are not as reluctant to consider such a referral as one to an outside agency.

Consultation with Staff Members

Regular morning meetings, usually an hour in length, were held with Mrs. Hale to go over various cases. We also often ate lunch together or met briefly in the late afternoon. Contacts with the doctors were informal and brief, though occasionally they requested time to discuss specific patients. All three physicians were interested in the emotional aspects of their patients' problems. Despite a heavy patient load they carried through effectively with suggestions made. The service unit director, Mr. Rhoads, was particularily helpful in answering questions about various tribes and Indian customs & culture. Since he is a Cheyenne displaced to the east we shared common interests and experiences.

Educational Activities

Four talks were given at Shawnee:

October 30, 1973 - IHS Mental Health Program in Oklahoma, to CHRs.

January 8, & 22, 1974 - Mental Health Problems in American Indians, to staff at in-service training sessions.

April 30, 1974 - Experiences at Shawnee; the Importance of Depression, also to the staff.

Only limited contact was made with the CHRs. Except for the one meeting listed above this was primarily focused around individual patient problems. One CHR did sit in on the group therapy sessions several times. Since so many tribes are involved at Shawnee it is harder to initiate regular sessions with the CHRs. However, since they are crucial to case identification and follow-up, efforts to work regularly with them should be intensified.

An additional aspect of educational activities was the inclusion of medical students when they were enrolled in electives with me. Three senior students participated in patient and group sessions learning about an aspect of health care in Oklahoma which was new and interesting for them. These students were William O. Smith, Jr., Patricia McKnight and Michael Bullen. One of these students now has plans to spend some time with IHS.

Participation in Area & National Meetings

March 21, 1974: A speech entitled, "Identity Crisis" was presented at the Native American Youth Conference attended by juvenile after-care workers, at the Center for Continuing Education, Norman.

May 23, & 24, 1974: The Indian Health Service, Mental Health Staff Training Sessions in Albuquerque were attended at the invitation of Mr. John Bjork.

SUMMARY

During 1973-1974, psychiatric consultation services to Shawnee Service Unit have included the following:

1. Direct Patient Services
    - a. Forty-five patients and family members in 8 instances, were seen for evaluation and/or brief therapy for a total of 89 interviews (4.8 per day).
    - b. Five patients were seen for 1 to 6 sessions in group therapy (average attendance 3.7 patients per session).
2. Consultation with Staff Members
    - a. Regular meetings were held with the social worker.
    - b. Frequent informal contacts were made with physicians and service unit director.
    - c. Written summaries were submitted on all patients seen.
3. Educational activities
    - a. Four talks on 3 topics were presented to CHRs or staff members.
    - b. Three senior medical students were supervised in activities at Shawnee.
4. Participation in State and National Workshops
    - a. Two such meetings were attended and a speech was presented at one.

Recommendations

The Shawnee Service Unit makes efficient use of psychiatric consultation time. It is a satisfying place to work for a consultant. Since it is only 42 miles from Oklahoma City it is possible to cooperate closely with the O.U.H. Psychiatric Service on referrals for more detailed evaluations or therapy. I would like to encourage a continuation of this relationship. Because of the good professional back-up at Shawnee a resident could profit from the experience of working there, as soon as another staff member is sufficiently acquainted with the service to provide supervision.

The group therapy endeaver has worked out well, promising to become a valuable resource. The pharmacist's role as co-therapist with the potential of becoming a major decision-maker regarding drug dosages should be pursued further. Pharmacists are able to carry out this task of adjusting medications in other chronic patient groups and can be a valuable resource for mental health patient care. I hope that the group can be continued.

Though my association with Shawnee Service Unit has been brief it has been a valuable experience and a real pleasure. My thanks go to all the Shawnee Staff and particularily to Mrs. Hale for making it so. Mr. John Bjork in the area office and Dr. Fernando Tapia in the Department of Psychiatry have provided consistently helpful back-up. Special thanks go to them and to my tolerant and always helpful family.

Mary Frances Schottstaedt

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Associate Professor of Psychiatry &
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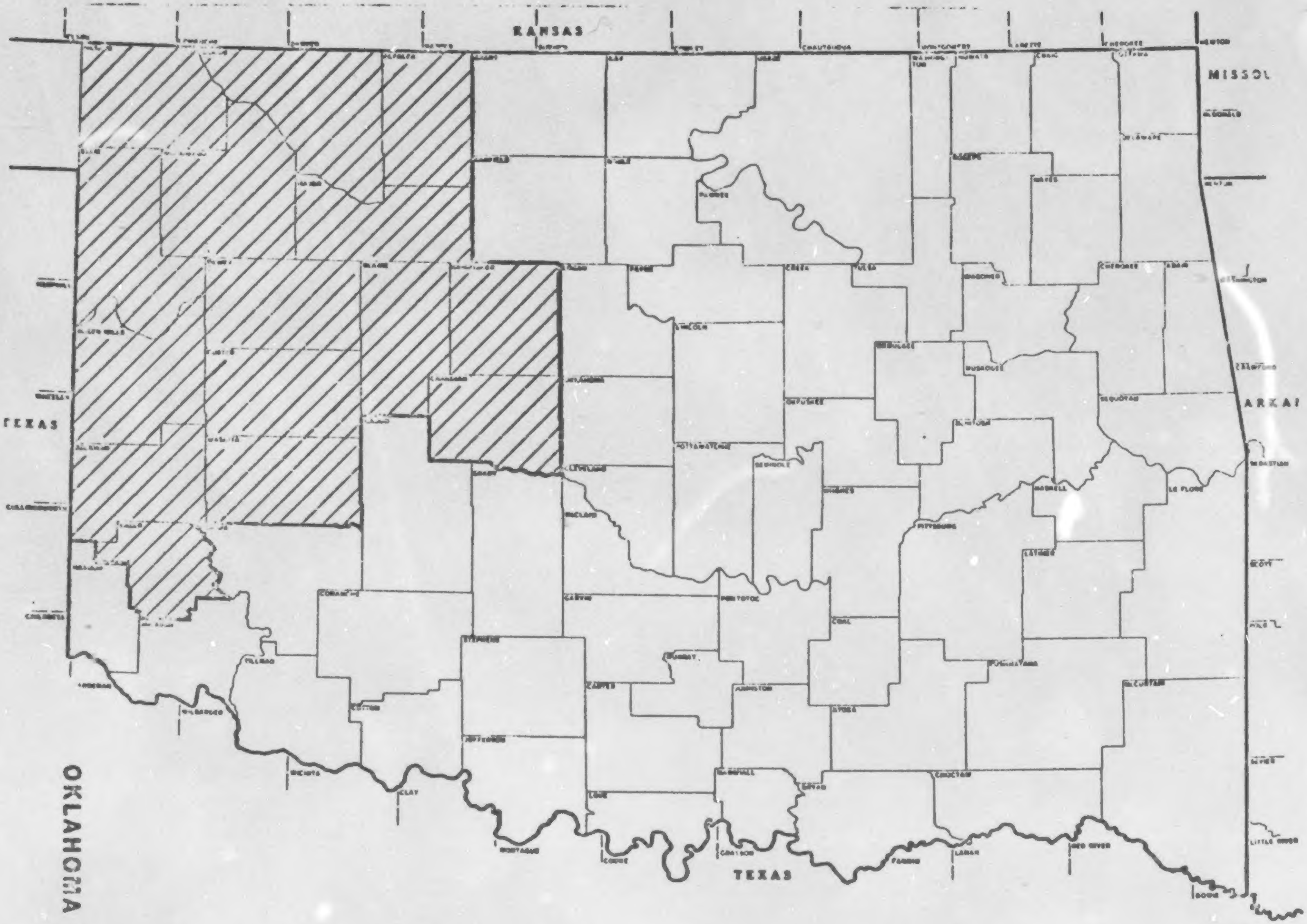
Oklahoma University College of Medicine

MFS/eh

Clinton Service Unit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77

78

F. Western Oklahoma

1. Clinton Service Unit

In the fall of 1970 Dr. Robert Gordon enlisted the assistance of Dr. Mary Frances Schottsteadt, of the Department of Psychiatry, University of Oklahoma Medical Center, as a consultant to the Clinton Service Unit. As has been noted, the Clinton Indian Hospital serves the Cheyenne - Arapaho tribes, who are widely scattered along the west-central to northwest quadrants of Oklahoma. Almost 5,000 Indian people scattered over 20,000 square miles utilize the Clinton Service Unit through its hospital at Clinton, and through field stations located in a variety of small communities and staffed on a variety of schedules.

For the first year Dr. Schottsteadt concentrated on direct patient services, with a goal of reaching as many patients as possible, briefly and helpfully, as a concrete demonstration of mental health services. A second goal, strongly desired, was to work with hospital staff so that they could better understand and deal with psychiatric problems. Meanwhile, Dr. Schottsteadt found it also essential to learn of the community agencies and cultural background of the Cheyenne - Arapaho people. She not only became familiar with referral resources, but also spent time in home visits, community celebrations, powwows, and school programs.

Other staff at Clinton are Arthur Rowlodge, Mental Health Specialist, and Jolyne Toppak, Secretary. Mr. Rowlodge has had intensive training in Alcoholism counselling. His work is described in the 1974 Area Annual Report as follows:

> "The Clinton Mental Health Specialist has developed a program in keeping with the major mental health problem in the service unit and with the intensive training he received in FY 72. His focus is on the problem of alcoholism and he provides consultation to Alcoholics Anonymous groups, including Alanon and Alateen, on a regular schedule each day of the week. He shows and discusses films on mental health topics to community groups. He interviews patients and their families to provide treatment and referral services, and he provides consultation to community agencies about the needs of the patients. Mr. Rowlodge is currently enrolled in a course on Wechsler testing at Southwestern State College, Weatherford."

The first annual report (June, 1971) of the Mental Health Program at the Clinton Service Unit summarizes the basic method of service delivery adopted by Dr. Schottsteadt and also outlines some of the problems faced. The report is quoted almost in its entirety since it describes succinctly this pattern of Mental Health program initiation and development.

"CLINTON INDIAN HOSPITAL PSYCHIATRIC CONSULTATION SERVICE

September 1970 - June 1971

Thirty regular weekly visits have been made to the hospital. These days have been spent primarily seeing patients referred to me by the physicians, nurses, and community health representatives. Other activities have included didactic sessions followed by group discussions with the nursing staff, informal consultations with staff members regarding patient evaluation and management as well as personal problems, and contacts with other agencies serving the Indian population in the area (such as Clinton Guidance Clinic, Halfway House, and Committee of Concern). In an informal way I have served as a liaison person with the University of Oklahoma Medical Center, obtaining information about patients referred here, arranging for visits to the center, seeing patients or staff who have been hospitalized, and obtaining reference materials.

Community and Tribal Activities

In addition to the regular consultation days, ten days and three evenings have been spent on activities relating to Indian Health or Cheyenne-Arapaho affairs. These include the following:

August 13, 1970	Clinton Indian Hospital with Dr. Gordon; visits to homes in Clinton with Clyde Armstrong, CHR
August 20, 1970	Visit to homes in Seiling with Bertha Little Coyote, CHR
September 3, 1970	Visit to Kingfisher, Watonga, and Canton Clinics and homes with Marquerite Spicklemeier, P.H.N.
September 6, 1970	Annual Cheyenne-Arapaho Pow Wow at Colony
November , 1970	Pow Wow at Colony to benefit the hospital
April 12, 1971	Western State Hospital visit
April 16, 17, 18, 1971	Committee of Concern Camp-Out for Teenagers, Red Rock
May 6, 1971	Visit to homes in Clinton with Lawrence Hart and trip to Hammon
May 14, 1971	Association of American Indian Physicians Meeting
May 21, 1971	Clinton High School Graduation
May 27, 1971	Oklahomans for Indian Opportunities State Meeting, Norman

Topics which were presented and discussed in staff conferences were the following:

Depression	Adaptive Mechanisms
Suicide	Asthma
The Hostile Patient	Negative Attitude
The Dying Patient and His Family	Crisis Intervention
Anxiety	Transactional Analysis

These conferences provided a jumping off point for discussions of patient management problems and personal relationships on the job, at home and in the community. From my own point of view they were very useful in providing insights to Indian History and culture, personal acquaintance with a number of staff members, and some idea of the hospital community hierarchy and interactions.

Clinical Caseload

[46] patients [were] seen at Clinton Indian Hospital from September 10, 1970 to June 3, 1971. . . . As is usual with psychiatric populations many patients could have been listed in several [diagnostic] categories. Many of those with acute neurotic or situational problems had underlying personality disorders.

Chronic problems with alcohol played a part in the difficulties of 15 patients. Four boys were admitted paint and glue sniffers. Seven patients had made recent suicide attempts. Acute or unresolved grief was present in 17 patients. Of 17 patients seen between the ages of 6 to 18, four were not attending school, and five were having academic and/or behavioral problems sufficiently severe for their parents to be concerned about them. Eight were reportedly doing satisfactory work, though four of these changed schools mid-year. In addition to the above [illegible]. patients, several hospital employees were seen on a continuing basis, and numerous informal consultations about personal or work problems took place.

It can be surmised from the above that problems around dependency are prominent in this population. Whether this is simply a reflection of low socio-economic standing or has more to do with Indian culture, family patterns and child-rearing practices is an intriguing question. My impression is that the latter factors are highly significant. Babies come along very early in life. Grandparents and other relatives often provide the primary care, and Bureau of Indian Affairs boarding schools may be the next resort (less so in the present generation). This sets children up for multiple unmet needs and serious early losses. Hostility is poorly modulated either being openly and violently expressed, or handled by attempts at denial and suppression. Indeed verbal behavior for discharge of affect or problem-solving seems alien to these people. This complicates the use of psychotherapy.

Administrative Difficulties

The main problem areas are: 1) inefficient use of time, 2) lack of regular personal communication with other staff members, 3) lack of follow-up.

1) I have seen from one to eight patients per day. Parents and other family members have been interviewed in a number of instances. However, it seems virtually impossible to adhere to a schedule. We now routinely over schedule and all patients are seen who make it to the hospital. It may be possible to organize things so the Community Health Representatives play a more active role in getting patients to appointments, especially first appointments when apprehension is greatest, or the Mental Health worker may be able to help with this. Free time is spent visiting informally with staff and hospital patients. I have deliberately used a room in the hospital for my interviews in an effort to make maximum contact with patients and physicians.

2) Because physicians are often out in field clinics, or are apt to be swamped with work if in the hospital, it has been hard to find ways to share information with them, much of which I hesitate to put in the written records. The present physicians rarely discuss cases with me, but see their role as one of getting patients to come to see me. This can be structured differently with the new physicians, thus expanding my consultant role. Regular contacts with other staff members are equally important.

3) Lack of follow-up has often left me wondering whether therapy has been effective or not. In rare instances there has been some feedback such as referral of a relative, or some gesture of appreciation and thanks. In most cases I do not know whether the patient stopped coming because he regarded himself sufficiently improved or because of frustration over slowness of progress, fear of change, fear of the therapeutic relationship, irritation at my counter-culture interpretations, or the impracticality of a psychotherapeutic approach to the kinds of problems these people experience. Perhaps the answer is important only in terms of my learning to work effectively with this group and to adapt techniques to their needs. Again Community Health Representatives and the Mental Health Worker may be able to provide follow-up information if requested to do so and given some guidance about how to approach this task.

Plans for Next Year

In planning for the next year I hope to:

1) Expand my role as a consultant, helping physicians and other staff members to evaluate and treat or manage patients themselves. I want to continue a certain amount of direct patient care, to enlarge my own experiences and background, as well as to provide service. However, the time and service will stretch further if I can educate others.

2) The staff conferences were a valuable use of time and might be scheduled once or twice a month on a regular basis, again with topics suggested by the staff. Nearly any topic suffices to get a discussion going in the alert and concerned group working out at Clinton.

3) I'd like to start a group discussion on Well Baby Clinic Day, probably using some didactic approach to get it launched. As noted earlier, oral stage problems are so prevalent and severe in this population that working with new mothers regarding child rearing techniques and their own responses to their infants appears to be the most logical preventive approach.

With the valuable additions of an experienced Social Worker and Mental Health Worker this program can grow and expand and exert a positive influence upon the problems of the Cheyenne-Arapaho people.

Mary F. Schottsteadt, M.D."

It is interesting to trace the positive expansion of this program over the succeeding years. In addition to a regular schedule of visits at the Clinton Indian Hospital, Dr. Schottstaedt has added once a month visits to two clinical satellites of this Service Unit.

Watonga, a small community of less than 2,500 people, has recently arranged for a Health Center facility leased from the Tribe and staffed regularly by IHS personnel. Watonga is about ninety miles northwest of Oklahoma City, and fifty to sixty miles northeast of Clinton. It is not really on a road to any major Oklahoma town. Although there are State Park facilities near Watonga, it seems to sit alone on the open plains and prairies.

The Concho School is a BIA school serving elementary age children. It used to also provide dormitory space for students who attended the El Reno High Schools, but no longer does so. El Reno is a railroad division point, and the location of a federal reformatory. It is about forty-five miles northwest of Oklahoma City, on the eastern boundary of the Cheyenne - Arapaho territory.

The general goal of the Clinton program seems to be to arrive at a balance of half time in direct patient services and half time in community program consultation and support. Arthur Rowlodge, the Mental Health Worker at Clinton is particularly involved in the liaison and counseling activities of the Cheyenne - Arapaho Lodge to be discussed in the section on Special Programs. Dr. Schottsteadt's reports speak of her own involvement in the community as well as her clinical caseload, and the subsequent ones through 1974 are added so that a complete picture of this Service Unit can be made available.

CLINTON SERVICE UNIT, INDIAN HEALTH SERVICE

Psychiatric Consultation Service

Annual Report
June 1, 1972 to June 1, 1973

The third year of psychiatric consultation work at the Clinton Indian Hospital has involved a greater diversity of activities than heretofore. These have included:

1. Direct patient services at Clinton and Watonga.
2. Consultation with other staff members.
3. Didactic presentations and discussions with staff members.
4. Consultation at Concho BIA School.
5. Participation in group discussions at the Cheyenne-Arapaho Lodge at Bessie.
6. Consultation, didactic presentations and discussions with Youth Services Project staff of the Committee of Concern.
7. Participation in grant request planning and writing.
8. Participation in several area workshops.
9. Participation in a symposium at a national meeting.
10. Liaison activities with Indian Health Service and Oklahoma Health Sciences Center.

Direct Patient Services

It was decided last year that more consultation time should be spent with staff and community activities. Consequently, patients were scheduled only in the afternoons at Clinton. Patients were also seen at Watonga but not at Concho. A total of eighty patients were seen, for 155 interviews, averaging 4.3 per day, compared to 5.8 last year. Fifty-four of the patients were seen for the first time during this year. Once again the emphasis has been on evaluations, 95 per cent of the patients having been seen four times or less, and 81 per cent just once or twice. One patient was seen nine times at Oklahoma University Hospital. She was a student at Oklahoma City University who developed psychophysiologic symptoms as she approached graduation. She graduated symptom-free and has remained well since. Another patient was seen twelve times. She was one of the children referred to in last year's report who lost her mother at age twelve. She was seen for a total of thirty-four interviews and is now doing well in a foster home, attending public school and reaching the appropriate developmental milestones. She will be seen only for follow-up during the coming year.

The diagnostic categories into which this year's patients fall are similar to last year's. The same criteria have been used, namely, listing patients according to their presenting or most immediate complaint and being well aware that most had underlying personality problems as well.

Main Diagnoses	No. Patients 1972-73	No. Patients 1971-72	No. Patients 1970-71
Acute and chronic brain syndromes	4	4	3
Psychoses and borderline states	7	7	1
Personality disorders	16	7	5
Psychophysiologic reactions	5	2	7
Psychoneuroses	31	38	23
Anxiety	5	9	9
Depression	26	29	14
Behavioral problems	7	6	1
Situational reactions	8	14	6
No psychiatric diagnosis	2	2	0
Total	80	80	46

The increase in patients considered to be primarily personality disorders can be attributed to the referrals of chronic alcoholics from the Cheyenne-Arapaho Lodge during this past year.

The age distribution of patients seen follows:

Age	No. Patients 1972-73	No. Patients 1971-72	No. Patients 1970-71
0-9	0	3	4
10-19	21	25	17
20-29	19	17	9
30-39	16	10	9
40-49	18	15	11
50-59	4	6	4
60-69	2	3	1

The trend is toward seeing older patients. Thirty-five percent were teenagers or children last year as compared to 26 percent this year. This may be a reflection of increased services available to young people through groups organized by our Mental Health staff last summer, through the Guidance Clinics and through the Youth Service Project. In terms of preventive psychiatry it is not a desirable trend.

In addition to the above, home visits were made with public health nurses to 11 families. Four patients were followed during hospitalizations at Oklahoma University Health Sciences Center. . .

The most striking thing in my mind is the pervasiveness of depression in this population. From 32 percent to 36 percent were diagnosed as primarily depressed during the past two years. An additional 14 patients this year were suffering from depression or grief reactions, though their primary diagnosis was considered to be something else. Thus 50 percent of patients seen during this year were depressed or grieving. When one considers the relationship of loss, depression, hopelessness and helplessness to the onset and outcome of illness it seems logical to consider a carefully planned campaign against this mental health problem.

Consultation with other Staff Members

Regular meetings were held with Mr. Albaugh, social worker, on days spent at Clinton. When his schedule permitted, Mr. Rowledge, mental health worker, was also present. These sessions were used to exchange information re patients and program plans.

An effort was made to meet regularly with the physicians. This was accomplished on rare occasions only. Most contact with the physicians was in the nature of quick conversations in between patients, and phone calls to and from Oklahoma City.

Written psychiatric summaries were furnished on all patients seen during the year. Initially, these were filed in separate mental health files with the plan that the secretary would deliver these to the physicians on request. This never happened. Information on in-patients was being relayed verbally during ward rounds by Mr. Albaugh. On out-patients it was not available. Consequently, I began to send copies of the summaries directly to the referring physicians. Follow-up notes are regularly put into the medical records. No system of follow-up notes has been evolved for the mental health files. At this point the usefulness of separate files needs to be re-examined. Are we not perpetuating the mind-body dichotomy with this system? Any information which can be of use in the care of a patient needs to be readily available to the physician in charge.

Didactic Presentations to Staff Members

A series of talks on mental health topics have been presented to staff members, including community health representatives, maternal-child health workers and mental health workers. These have been scheduled at monthly intervals, on Wednesday afternoons at Clinton during last summer and fall, and then on Thursday mornings at Concho Agency the rest of the year. These talks have served as springboards for discussions of patient problems. The following topics have been presented:

July 12, 1972	Depression
July 27	Maternal Deprivation
August 9	The Dying Patient and His Family
September 13	Suicide
October 12	Crisis Intervention
January 18, 1973	Case History of a Deprived Child
February 8	Guidelines for Talking with Patients
March 8	Communicating with Symptoms
April 12	Understanding Schizophrenia

The following meetings were held with physicians:

June 29, 1972	Case presentation: nineteen-year-old car accident victim with depression
February 1, 1973	Talk on Psychoactive Drugs
May 3, 1973	Case presentation: thirty-eight-year-old chronic alcoholic

The timing and location of meetings with field health staff pose problems. It is difficult for me to arrange my schedule at the University so that I can be away on different days of the week, and thus accommodate to times when the staff members are meeting for other purposes. Concho is at the edge of the service unit area, so that for meetings held there several of the community health representatives had very long and early morning drives to make. Now that the Watonga Clinic is expanded it might be an alternative location for the meetings. Or perhaps time at the hospital should be used in this way. I feel that these sessions are a valuable use of time and hope to be able to continue them.

Consultation at Concho BIA School

One-half day per month has been spent at Concho School since October, 1972. This service was requested by Mr. Tillman, superintendent, who specifically desired that employee attitudes and behavior toward the children be modified. He felt that the students had no more problems than one would find in a public school population. He did not want individual children seen, and should this be requested the channels to obtain permission were complex and via disciplinary routes. Mrs. Kunneman, the public health nurse stationed at the school had a broader goal in mind in promoting mental health consultation. She was acutely aware of the problems and needs of the children and was making every effort to help with these.

The approach evolved for Concho was:

1. to meet individually with key counselors and supervisors to get a feel for problems as they perceived them and to offer ideas for resolution;

2. to meet with the girls' dormitory personnel as a group, again to get their views on problems, their ideas for solutions and to attempt to modify their attitudes and behavior in the process;

3. to meet with the school health committee to keep in touch with the overall health picture and to have some contact with teachers and students;

4. to work toward meeting some of the needs of the students.

It was immediately apparent that the dormitory aides are faced with a superhuman task, that of caring for 256 children, ages 5-16, most of whom attend the school because of family disorganization, parental loss or neglect and overall deprivation. They are asked to do this in a ratio of one adult to sixty children. The whole setting breeds crisis situations to which the staff respond in punitive and frustrated fashions. The meetings with counselors and supervisors were useful in establishing rapport, allowing for ventilation, offering some help with specific problems which was subsequently acted upon. The efforts to work with the girls' dormitory aides were educational for me but did not effect any significant changes in attitudes or behavior on their parts. In fact they became rather hostile and suspicious of the whole process.

Efforts to meet some of the needs of the children were made in two ways. Ann Weaver, social worker with the State Mental Health Drug Abuse Program agreed to spend one afternoon per week at the school seeing individual children. Our plan to have her start a group for glue sniffers during the spring did not work out. Also Mr. Albaugh, the hospital social worker, kept in touch with children he knew by occasional visits.

Permission was obtained to use volunteers at the school. An elective course was then offered to freshman medical students at the Oklahoma University College of Medicine. Three students, Nancy King, Ron Robinson and Gary Harris, agreed to spend one evening per week (4:00 pm to 8:00 p.m.) learning to know the children and relating to them in a non-demanding, warm, and interested fashion. They became very engrossed in this project and provided a new emotional experience for at least some of their young friends. The medical students made fourteen regular trips to the school. In addition, they attended weekly supervisory sessions with me, during which we also took up topics pertinent to this experience. These included:

Historical Perspective of the Cheyenne-Arapaho Tribes
Value Systems, White and Indian
Indian Health Service, One Form of Health Care Delivery
Indian Health Statistics Over the Past Fifteen Years
Disease Distribution: White vs. Indian and Between Various Tribes
Small Town Dynamics (presented by Dick Swift)
Mental Health Programs (presented by John Bjork)
Group Dynamics

Though the focus was on mental health, the students also encountered some interesting medical problems: brain-damaged children, genetic defects, death of an employee from an infectious disease which presented an epidemiologic problem of some magnitude as well as an opportunity to observe grief reactions, a chicken pox epidemic, poison ivy, Sydenham's chorea and head lice. The students were viewed with suspicion at first but won over the staff and I have been asked to send more like them next year.

As the result of a workshop held in Clinton (to be discussed in a subsequent section) a panel from the Health Sciences Center was invited to appear at Concho to lead a discussion on the general topic of caring for children. This meeting was held April 23, 1973. Panel members included Ms. Anita Odom, Educational Coordinator, In-Patient Psychiatry Services, Larry Prater, M.D., Chief Resident in Psychiatry, Jim Taylor, fourth year medical student, and myself. Boys' and girls' dormitory aides, counselors, and several teachers attended. An active discussion ensued and we were asked to return again.

On May 10, 1973 Dorothea Dolan from the Rural Mental Health Desk at National Institutes of Mental Health visited Concho School with me. Her purpose was to help us to plan for further improvements in living conditions for children at the school. Her ideas, interest, and support will be most helpful if we are able to submit a grant request to support mental health activities at the school.

In summary, a start has been made in introducing a mental health program at Concho School. The choice of a new superintendent will be crucial in whether the program can be continued and expanded.

Cheyenne-Arapaho Lodge

Visits to the Lodge were made four times during the year. On two of these occasions I participated in the morning group discussion with all of the patients. Eleven patients were seen at the hospital for psychiatric evaluation.

Activities with Committee of Concern

The Youth Services Project is one of several activities sponsored by the Committee of Concern, a non-profit organization dedicated to helping members of the Indian Community in five Service Unit counties: Beckham, Blaine, Custer, Dewey and Roger Mills. The Youth Services Project maintains a home in Clinton where children in need of help can be cared for briefly. It sponsors clubs for Indian youngsters in public junior and senior high schools. It runs a summer program, Project Pride, consisting of remedial and Indian-oriented activities both educational and recreational, in the elementary schools in six communities. Through a developing network of volunteers it offers supportive relationships to individual Indian children. The staff during the past year, headed by Lawrence Hart, has included Terry Stocker, Brian and Carol Harder, Betty Hart, and Susan Chapman. Regular meetings were held with this group from October through March at the hospital or at a bank downtown in Clinton. The following talks were presented:

October 5, 1972	Adaptive Mechanisms
October 19	Crisis Intervention
November 16	Depression
December 7	Suicide
January 18, 1973	Case History of a Deprived Child
February 1	Erikson's Developmental Stages (through latency)
February 15	Erikson's Developmental Stages (adolescence)

These sessions were usually two hours long. A period of active discussions occupied part of the time. When specific problems arose in one of the programs the second hour was used for discussion of these.

The house parents, Brian and Carol Harder were a most unusual, dedicated young couple who maintained on-going relationships with a number of Indian children who had been in their care at some time during the year. They provided role models, interest, support, and encouragement which had a significant impact on these youngsters. Supervision and support was provided to them through this consultation service, as well as to Terry Stocker in her program planning and work with individual children through volunteers and the courts.

In the course of developing the volunteer program a need for orientation and training was recognized. Out of this arose the idea of a workshop. This was ultimately titled "Caring for Children Not Your Own" and was held March 10, 1973 at the First Methodist Church in Clinton. The audience, numbering about 150, included volunteers, foster parents, service workers administrators from Department of Social and Rehabilitative Services, Concho School dormitory aides and counselors, field health staff and community health representatives, and Committee of Concern staff and board members. The program for the day included two speakers: Dr. Povl Toussieng on "Counseling the Adolescent of Today," and Ms. Anita Odom on "Techniques in Behavior Modification," both from the Department of Psychiatry and Behavioral Sciences, Oklahoma University College of Medicine. A panel consisting of the two speakers, Dr. Larry Prater, Chief Resident in Psychiatry, John Bjork, Chief Mental Health Branch, Indian Health Service, and myself was moderated by Bernard Albaugh, also from Indian Health Service. The program and the evaluation summary will be found inthe appendix. The overall response to the day was positive.

A further project in conjunction with the Youth Services Project was the development of an expanded summer program for the community of Hammon. Hammon endured a minature Wounded Knee kind of episode during the spring. A Freedom School for Indian children was established there. Youth Services Project was asked to offer remedial work at all levels to enable those students who so desired to re-enter public school in their same grade level next fall. Plans for expanding the Project Pride summer program were developed during a day long meeting on April 5, 1973. Dick Swift who deserves much of the credit for the reduced drop-out rate of Indian children in the Carnegie Schools attended this meeting, as did representatives of the Episcopal Church, Oklahoma Crime Commission, Hammon Public Schools and Churches, and Indian Health Service. The program this year started with a week-long workshop for teachers conducted by Mr. Swift and directed at modifying their attitudes toward Indian children. An expanded educational and recreational program is in operation now in Hammon.

Participation in Grant Request Planning

One of the goals stated in last year's report was to develop an early intervention plan for our territory based upon ideas from "Operation Early Chance," a Portland area program. Such a grant request was written and has found its way to Washington, D. C. Just where it might ultimately be submitted formally is not known. The Oklahoma State Health Department might be approached also for financial assistance. The longer I work with the Cheyenne-Arapahos the stronger I feel about concentrating our efforts on the mother-infant dyad.

Participation in Area Workshops

Several speaking engagements related to this consultation service were:

April 24, 1973	"Defining Therapeutic Use of Self and Its Use in Family Centered Care" at a workshop on family-centered nursing care for Indian Health Services Nurses
May 19, 1973	"Clinical Aspects of Mental Health" at the Indian Mental Health Seminar

Participation at a National Meeting

December 3, 1972, I attended the Interdisciplinary Colloquium "Psychoanalytic Questions and Methods in Anthropological Field Work" at the American Psychoanalytic Association meetings in New York. This five-hour marathon session dealt with ghost sickness in the Kiowa-Apache of Oklahoma and with Arctic Hysteria. This was a valuable experience in that it contributed to my understanding of the process of mourning in an Indian culture.

Liaison Activities Between Indian Health Service & Oklahoma University Health Sciences Center

The last goal for the year, to encourage cooperation between the Service Unit and the Health Sciences Center has not been covered adequately above. In addition to liaison services for patients and the workshops and panels mentioned above I have provided contacts for faculty and visitors in the Service Unit. These have been mutually advantageous and have included the following:

1. Helen Hetzel who shared her experiences with Lifeline and Mother Craft programs in Melbourne, Australia with the Youth Services Project staff.

2. Elizabeth Eggleston, from the Law School at Monash University, Melbourne, Australia who spent a day with Lawrence Hart in conjunction with her study of differential treatment in the courts of aboriginals and whites in Northern Australia and in Phoenix, Oklahoma City, Chicago.

3. Dr. Jiro Nakano, Departments of Pharmacology and Medicine, who presented talks to the physicians and the Bessie residents on the metabolism of alcohol. He is hoping to be funded to do a comparative study of metabolic pathways of alcohol in whites and Indians.

Goals for 1973-74

The following is a suggested use of time for the coming year:

1. Continue to offer direct patient services at Clinton and Watonga. My own feeling is that a greater portion of this time should be devoted to brief therapy with young people, particularly mothers of young children. A better follow-up system needs to be devised so that all of us will know what avenues have proved beneficial.

2. Continue regular meetings with social service and mental health workers. I hope to work more closely with Mr. Rowledge during the year. He is welcome to share all interviews with me, and I would like to work toward conjoint therapy so that he is not only an observer, but rather an active participant. New physicians will be coming in July and I will hope to respond to their desires in terms of referrals, supervision, and conferences.

3. Continue to meet with field health staff members on a regular basis (two hours per month).

4. Expand consultation services at Concho School if the new superintendent and school board so desire. This would include continued use of medical student volunteers and other volunteers if supervision can be provided. It would include developing a grant request to seek support for a mental health program at the school. This is conceived as a program to better meet the emotional needs of all the children, and not simply to provide help to those in trouble.

5. Participate on a regular basis in group discussions at the Cheyenne-Arapaho Lodge (two hours per month).

6. Continue consultation services to Committee of Concern (two hours per month).

7. Look more aggressively for funding for "Operation Early Chance - Oklahoma Style."

8. Respond to requests for participation in other Oklahoma City area activities.

Once again I wish to thank those who have helped me in carrying out the activities of the past year: the staff members at the Clinton Indian Hospital, Watonga Field Health Clinic, and Concho School; the staff members at the Cheyenne-Arapaho Lodge and Committee of Concern; my colleagues at the Oklahoma University Health Sciences Center; Mr. John Bjork at the area office and particularly my husband who has supported this endeavor in more ways than can be enumerated.

Mary Frances Schottstaedt

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Associate Professor of Psychiatry,
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CLINTON SERVICE UNIT, INDIAN HEALTH SERVICE

Psychiatric Consultation Service

Annual Report

June 1, 1973 to June 1, 1974

This is the fourth year during which weekly trips have been made to the Clinton Service Unit to provide psychiatric consultation services. The range of activities has been similar to that of last year, including roughly 50% direct patient services, and 50% educational & cooperative efforts with staff and community groups. Specifically, activities have included:

1. Patient evaluations, brief therapy, and drug maintenance at Clinton Indian Hospital and Watonga Field Clinic.
2. Educational endeavors and consultation with Indian Health Service-tribal staff members, including social service and mental health workers, physicians, nurses (hospital and public health nurses) community health representatives, maternal-child health workers, tribal community out-reach workers, and Cheyenne-Arapaho Rehabilitation Lodge staff.
3. Supervision of a summer clinical psychology trainee.
4. Consultation at Concho BIA School, including a major commitment to developing a grant request to support a treatment program for inhalant abusers at the school.
5. Educational and consultative services to Committee of Concern, a non-profit Indian organization dedicated to helping the Indian people in five western Oklahoma counties.
6. Participation in area and national workshops.
7. Liaion activities with Indian Health Service and Oklahoma University Health Sciences Center.

Forty-five regularly scheduled days in the Service Unit were the following:

CLINTON	WATONGA	CONCHO
June 7, 14, 21, 1973	July 26, 1973	Aug 30, 1973
July 5, 12, 19, 1973	Aug 23, 1973	Oct 11, 1973
Aug 2, 31, 1973	Sept 27, 1973	Nov 8, 1973

CLINTON

Sept 6, 20, 1973
Oct 4, 18, 1973
Nov 1, 15, 1973
Dec 6, 20, 1974
Jan 3, 17, 31, 1974
Feb 7, 21, 1974
Mar 7, 1974
Apr 4, 18, 1974
May 2, 16, 1974

WATONGA

Oct 12, 1973
Nov 29, 1973
Jan 24, 1974
Feb 28, 1974
Mar 28, 1974
Apr 25, 1974
May 30, 1974

CONCHO

Dec 13, 1973
Jan 10, 1974
Feb 14, 1974
Mar 14, 1974
Apr 11, 1974
May 9, 1974

Extra trips were made to Concho with volunteers, or in relation to the grant request on September 26, October 3, and November 12, 1973, and February 26, 1974. Halfday meetings were held at Oklahoma University Health Sciences Center and Indian Health Service regarding the grant on November 13, 1973, January 23, February 20, and March 29, 1974.

Direct Patient Services

Seventy-nine patients were seen during this year, as well as 15 family members (or caseworkers and lawyers), for a total of 175 interviews. This averages 4.9 interviews per day at Clinton and Watonga, up from 4.3 last year. Ninety percent of the patients were seen four times or less, in accord with the policy for psychiatric consultation time to be spent primarily on evaluations. Forty-three patients (56%) were seen only once during the year. Fifty-three patients were seen for the first time this year. Psychiatric summaries were written on all of these. Three patients were seen on home visits, and one child was seen at Concho.

Diagnostic categories reflect the most immediate problems with which the patients presented. Underlying personality disorders were present in many, as well as psychophysiologic or behavioral symptoms. The distribution of patients seen by broad diagnostic category is remarkably similar to last year's.

MAIN DIAGNOSES	# Pts. '73-'74	# Pts. '72-'73	# Pts. '71-'72
Acute and chronic brain syndromes	4	4	4
psychoses and borderline states	9	7	7
personality disorders	12	16	7
psychophysiologic reactions	5	5	2
psychoneuroses	33	31	38
Anxiety	6	5	9
Depression	27	26	29
Behavioral problems	6	7	6
Situational reactions	10	8	14
No psychiatric diagnosis	0	2	2
	79	80	80

The age distribution of patients seen in the past three years is given below:

	'73-'74	'72-'73	'71-'72
0-9	4	0	3
10-19	17	21	25
20-29	24	19	17
30-39	16	16	10
40-49	7	18	15
50-59	7	4	6
60+	3	2	3

Forty-four or 56% of patients seen this year were under 30 years of age.

However, in order to give a feel for the kinds of problems dealt with and the difficulties encountered some general descriptive statements and examples will be presented here.

The patients classified under Chronic Brain Syndrome included three with seizure disorders and one with craniostenosis and a life-long history of impulse disorders (fire settings, running away, aggressiveness, cruelty to animals, and peeping). An effort was made to provide a supportive, big brother sort of relationship for two of these teen-age boys. The mental health worker, or a summer social work student, maintained some contact with one, but the other quickly alienated the Southwestern State College student who tried to work with him. There was no real change in behavior patterns in either one. A preschool child with seizures and mild retardation has done quite well with support and encouragement provided to the mother, primarily by the well baby clinic staff. A program of verbal stimulation and school readiness was sought for her, but despite many phone calls and willingness on the part of the Indian Hospital Service to buy the materials these were not obtained. Mary Scott at Central State University has developed a suitable program which will be commercially available eventually and may prove useful for such children in the future.

The patients included under Psychoses and Borderline States are a diverse group including four chronic ambulatory schizophrenics, one of whom had pulled all of her hair out, and another of whom is a chronic alcoholic. Two women, considered borderline, are very difficult management problems. One drinks and sniffs constantly, manifesting severe anxiety, and the other has paranoid ideas, headaches and reduced vision and constantly demands pain shots at clinics and emergency rooms. Consideration has been given to psychiatric hospitalization but so far this has not been accepted by the patients. Another young woman in this group had an acute psychotic episode during withdrawal from alcohol which responded promptly to thorazine. One young man had an acute psychotic depressive episode which responded promptly to hospitalization at Oklahoma University Hospital and phenothiazines. He has worked steadily and lived comfortably with his family since. A young woman was also treated at Oklahoma University Hospital for a toxic psychosis secondary to drug abuse and was considered to have an underlying schizophrenic process. She continued in out-patient therapy after discharge.

The patients listed under Personality Disorders include 10 chronic alcoholics seen during their sojourn at the Cheyenne-Arapaho Lodge at Bessie. Twelve patients listed under other diagnoses were also considered chronic alcoholics in whom another problem prompted their seeking help. An evaluation was done on each and if some specific problem possibly modifiable by brief psychotherapy became evident, the mental health worker was encouraged to work with the patient more intensively at Bessie. Direct communication with Bessie counselors was not worked out, and some mechanism for this needs to be developed. The only patient in this diagnostic category who was not an alcoholic was a 16 year old boy with anti-social behavior, who was a sniffer among other things. He was AWOL from Granite Reformatory and was returned there after fracturing someone's skull.

The group of patients listed under Psychophysiologic Disorders is small primarily because when clear-cut anxiety or depression were present these diagnostic labels were used. Two patients with handicapping headaches of a tension variety, two with prominent gastro-intestinal symptoms and a severely asthmatic child are included here. An effort was made to get the asthmatic child into the Jewish Hospital in Denver, but the family rejected this plan. The boy was then referred to a psychologist in the nearest Guidance Center. Three of the other patients were seen for brief psychotherapy and one improved significantly.

The psychoneurotic group of patients is the largest and includes six in whom anxiety was the prominent symptom, usually revolving around anger over unmet needs or threatening life situations. The 27 depressed patients were a diverse group ranging in age from 8 to 65. Clear-cut loss of a family member by death, running away, or removal from custody could be identified in twelve of these patients. Because of duration of symptoms or preceeding personality these patients were listed here rather than under Acute Situational Reactions. Brief psychotherapy was sought for these patients, utilizing the psychology student, case workers from Department of Institutions and Social Rehabilatation Services, and the mental health worker, as well as the psychiatrist. Marital conflicts appeared to be prominent in six other patients. When possible the social worker saw the other spouses in these families. Nine patients presented pictures of long term chronic depression. Fifteen had suffered early loss of one or both parents. Eight had made suicide attempts in the recent past, four of which were significant threats to life. The general approach to these patients was to identify losses and deal with the grief reaction, identify anger and look for appropriate ways for expression and provide a source of support, concern and interest. All of the mental health staff participated in this. Eleven of these patients have been seen five or more times by the psychiatrist. Two have been referred to the in-patient unit at University Hospital, and another was referred for family therapy at University. Others were offered brief therapy but did not keep appointments. Depression continues to be the major and all-pervasive problem in patients seen for psychiatric evaluation at Clinton Service Unit.

The Situational Reactions are the patients in the midst of real life problems who appear to be handling them in appropriate ways: divorce, family problems, and physical illness are included here. Help with the real problems was offered whenever possible. Ventilation was encouraged and continuing support was offered to several.

The Behavior Problems include children and teen-agers who are acting out in such ways as "borrowing" cars, running away, and refusing to go to school. One seven year old was seen on a home visit on February 28, 1974, having refused to go to school all year. An effort is being made by the PHN to get her into Project Pride Summer Program. Guidelines for handling her were spelled out, but the parents are resistant to intervention. Two preschool children were evaluated because of their very demanding and dependent behavior in foster homes. Both foster mothers were given support and encouragement in a difficult task which they were handling well.

Five patients have been referred for in-patient care at Oklahoma University Hospital. A young man with a psychotic depression responded within a week and has done well since. A young woman with toxic psychosis and an underlying schizophrenic reaction stayed 10 days and continued in therapy with a resident, making good progress during the spring. A third, a teenage girl in trouble in her community because of homosexual behavior, was evaluated over a 10 day period but family involvement and continuing therapy were impossible due to distances involved. A fourth patient was admitted on an experimental basis a month after a serious suicide attempt. Our hope was that 10 days of the therapeutic community might have more impact than 30 minute contacts every two weeks at C.I.H. and might provide us with more understanding of this very common phenomenon. This patient signed out A.M.A. after two days. The other patient admitted to 5E was the child who lost her mother at age twelve, and was seen during the next three years with continuing behavioral difficulties. When her foster mother rejected her she became unmanagable. She stayed two months on the ward, seeming to make some progress in understanding herself. She was seen for 15 minute visits regularly during this period (about 40 times). However, she continued to behave aggressively toward others and had to be discharged, ironically on the 3rd anniversary of her mother's death. She has since been at Sand Springs Diagnostic Center, and is now at Central State Children's Unit. The rejections continue for her.

The problems in providing direct patient services in this setting are multiple, but when the challenges can be met, the satisfactions compensate. The appointment system at Clinton has remained an "open door" one. Patients themselves or any staff member can call the secretary to set up an appointment. No limit has been set on numbers, in order to encourage use of the service. Despite my efforts to stay on schedule, many patients have had long waits. An evaluation interview requires an hour, and return appointments are generally limited to 30 minutes. The patient selection, in terms of age range and type of problems, works out reasonably well this way. More careful scheduling, emphasizing the need to be on time, and written reasons for referrals would help.

The problem of record keeping was faced again. After discussions with the new physicians, the mental health staff, the Service Unit Director, and the Area Office Chief the decision was made to file psychiatric summaries in the medical records where they would be readily available and therefore maximally useful to physicians responsible for the medical care of the patients. Problems with confidentiality exist wherever these summaries are filed. Constant efforts are being made at Clinton to protect the medical records.

Educational & Cooperative Efforts with I.H.S. and Tribal Staff

Regular appointments were scheduled with the social worker and mental health worker during which specific patient problems were discussed. There were occasional times when emergencies or other commitments interfered with these meetings.

No scheduled meetings were held with the physicians. Contacts with them were informal catch-as-catch-can discussions of specific patient problems. All three physicians were new to the service unit this year. Our rapport has been good during the spring months particularly.

Monthly meetings were scheduled with the nursing staff during which didactic material or specific topics were presented and discussed. The pressure of patient care resulted in cancellations of these meetings several times. Topics discussed included the following:

October 4, 1973	Alcoholism
November 1, 1973	Motivation
February 7, 1974	Mental Health of American Indians
March 8, 1974	Maternal Attachment
May 2, 1974	Battered Child Syndrome

The nursing staff brought up problems of patient management informally, and were a receptive, dedicated, and friendly group to work with. The public health nurse at Watonga made particularly good use of consultation time. When she couldn't get patients to come in for evaluation she took me out to their homes, an instructive and sobering experience each time.

The community health representatives and maternal child health workers met with me regularly for two hours per month, usually at the tribal office at Concho. Topics presented and discussed at these sessions included the following:

August 31, 1973	Glue-Sniffing
October 12, 1973	Early Growth and Development
November 8, 1973	Battered Child Syndrome
December 1, 1973	Suicide
January 17, 1974	Mental Health of American Indians
February 14, 1974	Depression
March 14, 1974	Transactional Analysis
April 11, 1974	Sexual Development
May 9, 1974	Problems of Parents

Active discussion of patient problems usually ensued. Outlines of each topic were distributed. It is hard to evaluate the impact of these sessions myself. Hopefully they have contributed to an understanding of mental health problems wherever they are encountered. Certainly they did contribute to my understanding of the Cheyenne-Arapaho people.

Several visits were made to the Cheyenne-Arapaho Lodge at Bessie, during which I participated in the morning group meeting, answering questions posed by the patients. Discussion with Ellen Collin, summer psychology student, and George Hawkins, Director, regarding program planning and patient problems were also held. However, Mr. Hawkins has requested more feed-back regarding patients evaluated. An hour per month could be scheduled with him to go over cases.

Supervision of Summer Clinical Psychology Student

Ellen Collin, graduate student in psychology from State University of New York, Albany, New York, spent two months at Clinton Service Unit (June 11, 1973 to August 10, 1973). Planning and supervision of her activities was my responsibility. She participated in both IHS and community activities, including direct patient services, talks for staff members, consultation for staff at Bessie and in Project Pride summer school classes. Her training and orientation was behavioral, but she was open-minded and receptive of psychodynamically-oriented approaches. She administered Dorothea Leighton's Health Opinion Survey to Project Pride classes in an effort to assess stress levels in children living with parents versus children living with other relatives or foster families. The analysis of this data has not yet been finished.

Ellen spent two days with me at Oklahoma University Health Sciences Center, June 12, and August 3, 1973, as well as the seven days I had in the service unit during her stay. She sat in on interviews, presented cases, and accompanied me on all activities. She was free to phone me at any time at the city. Despite a certain amount of culture shock Ellen responded positively to her experiences at Clinton. Difficulties were encountered in selecting patients for her and in establishing a clear role for her in relation to other staff members. Though neither of us regarded the geographic separation as a serious handicap in her supervision, possibly more of my time should have been spent in dealing with staff reactions to her presence.

Consultation at Concho School

This was the 2nd year during which one afternoon per month was scheduled at Concho School. Regular meetings were held with Mrs. Kunneman, school nurse, Mrs. Penoi, Mrs. Curley, and Mr. Jones, counselors. Rather than setting up group meetings for dorm aides this year, the time was spent visiting informally with them in the dorm.

A major time commitment to Concho was the writing of a grant request in the hope of improving the dormitory milieu for all the children. Since inhalant abuse is a serious problem at the school and among western Oklahoma Indian youngsters generally, the grant was focused upon this and submitted to National Institute of Drug Abuse by the Cheyenne-Arapaho Tribe. Copies of the grant request are available at most locations where this report will go. The cooperation and active assistance of Mr. John Bjork, members of the Departments of Psychiatry, Human Ecology & pediatrics, the Concho staff, and the tribe were sincerely appreciated.

Once again volunteers for Concho were enlisted through the Elective Program at Oklahoma University College of Medicine. Joann Carpenter, M.S.i., spent an evening a week at the school throughout the year, and attended supervisory sessions with me every other week. Mel Harris, M.S.i., spent an afternoon every other week during the spring. Jan Bravo, psychology student at OU, Norman, worked weekly during the fall. Dr. & Mr. Joseph Ferretti, microbiology faculty member, went out every other week. Pat McKnight, M.S.IV, and her husband went out for five evenings during the spring. All these volunteers learned to know as many children as possible, the idea being that getting acquainted in a friendly fashion would provide the children with a different sort of experience with adults, a warm and non-demanding one which might enhance their self esteem a bit. Forty books were introduced in the boys' dorm, 37 of which were readily found at the end of the semester. Observations and ideas of the volunteers contributed to the development of the grant proposal. It is hoped that the use of volunteers can be expanded next year.

In conjunction with a trip to Claremore Indian Hospital on May 17, 1974, the Seneca Boarding School was visited. It was noteworthy that many of the changes which we hope to institute at Concho have already been made there. The possibility of using Seneca as a control school will need further exploration if the grant is received.

One further activity at Concho was arranging for the Casady School Choir to present a program at the school. This was done just before Christmas on a foggy wet night, and was well received by the Concho children, as were the candy canes distributed afterwards. We hope the Concho Choir will visit Casady sometime in the future.

Educational and Consultative Services to Committee of Concern

The Committee of Concern is a non-profit Indian organization dedicated to helping the Indian people in five western Oklahoma counties, (Custer, Blaine, Roger Mills, Dewey, and Beckham). Monthly meetings were held with their staff at a bank in downtown Clinton. The following topics were discussed:

September 6, 1973	Crisis Intervention
September 20, 1973	Depression
October 4, 1973	Transactional Analysis
October 18, 1973	Therapeutic Relationships
December 6, 1973	Counseling Indian Students
January 31, 1974	Developmental Stages (I-IV of Erikson)
February 21, 1974	Adolescence
May 16, 1974	The Concho Proposal

Staff attending included Youth Service Project and Adult Offender counselors, house parents for the children's shelter, and occasionally DISRS case workers. Active discussions were encouraged. These individuals made direct patient referrals during the year. During the summer, time was spent visiting Project Pride classes and getting acquainted with the Mennonite Volunteers. Ellen Collin was supervised in her group work with these young people.

This contact with Committee of Concern provides an important link with the Indian community, and is a valuable part of the consultation service.

Participation in Area & National Workshops

The Native American Youth Conference was held in Norman on March 21, 1974, and attended by juvenile after-care workers and others working with Indian youngsters. A speech entitled "Identity Crisis" was presented at this conference.

The Indian Health Service Mental Health Staff Training Session was held in Albuquerque May 23-24, 1974. At the invitation of Mr. John Bjork , I attended these meetings, a worthwhile and interesting experience.

Liaison Activities: OUHSC & IHS

The areas in which liaison activities were carried out included primarily patient referrals to OUH, and supervision of medical student elective activities in IHS and BIA settings.

The in-patient psychiatric ward at OUH, 5E, has changed from a long-term intensive treatment unit with very stringent criteria for admission to an acute treatment service with more of an open door policy. This plus willingness on the part of the CIH staff to allocate contract dollars, has made it possible to refer selected Indian patients to the unit. The staff on 5E in turn has made a real commitment to helping these patients, and to learning as much as possible about Indian culture to maximize their impact. Dr. William Hamilton, the therapist for three of the Cheyenne-Arapho patients, deserves special commendation, as does Cleo Dumas, the sponsor for the girl who stayed two months.

Arrangements for out-patient therapy at OUH were made for one family whose 15 year old daughter made a serious suicide attempt. Since the father was a fellow professional it was helpful to have them seen outside of the service unit.

The availability and willingness of Dr. Fernando Tapia to discuss problem cases with me has been most helpful. He has also contributed to the growing interest of the department in finding ways to help Indian patients. He spent a day, May 2, 1974, with me at Clinton, visiting the hospital, the Youth Service Center and the Cheyenne-Arapaho Lodge, contributing to the activities at each place. I am grateful for all of this.

Besides the patients hospitalized on 5E, I also visited Clinton patients hsopitalized elsewhere in the center.

In addition to the activities of students at Concho School which were described in that section, three seniors have had elective periods of five weeks during which they accompanied me on IHS rounds. These students were William O. Smith, Jr., Patricia McKnight, and Michael Bullen. All participated actively in patient evaluations, individual and group therapy sessions and the various conferences and meetings. One of these students, Bill Smith, hopes to work in Indian Health Service in Oklahoma. He has my complete support and confidence.

SUMMARY

During 1973-74 psychiatric consultation services to Clinton Service Unit have included the following:

1. Direct patient services:
    a. Seventy-eight patients seen for evaluation and brief therapy in 175 interviews.
    b. Home visits to three families.
    c. Regular visits to five patients hospitalized during the year on 5E.
    d. Occasional visits to Clinton Service Unit patients hospitalized elsewhere in the OUHSC.
2. Consultation with staff members:
    a. Regular appointments with the social worker and mental health worker.
    b. Infrequent and brief sessions with the physicians.
    c. Regular time with the public health nurse in Watonga.
3. Educational efforts with staff members
    a. Monthly meetings with the hospital nursing staff at which five talks were presented.
    b. Monthly 2-hour seminars with community health representatives and maternal child health workers, at which nine talks were presented.
    c. Supervision of a clinical psychology student during a summer of work at Clinton.
4. Consultation at Concho BIA School
    a. Regular conferences with nurse and counselors.
    b. Informal contacts with dorm aides.
    c. Preparation of a grant request to institute a treatment program for inhalant abusers.
    d. Supervision of medical students and faculty member volunteers at the school.
    e. Visit to Seneca BIA School, on the east side of the state.

5. Consultation to Committee of Concern:
    a. Eight talks to their staff.
    b. Individual patient consultations.
    c. Supervision of summer psychology student's activities with Project Pride.
6. Participation in a state and national workshop.
7. Liaison role between IHS and OUHSC:
    a. Direct patient services, referrals and continued contact at OUH.
    b. Supervision of medical students in IHS and BIA settings.

Because my own plans for next year remain indefinite it is not possible to state specific goals at this time. Only very general statements can be made. The consultation time spent in educational endeavors with staff and community groups is the most valuable in terms of long range gains for mental health. Emphasis in direct patient services needs to be concentrated on young families, currently involved in child-rearing, in the hope of preventing severe problems in the next generation. Time and energy spent on school-age children, and on helping others involved with them, should also be high in priority. Developing a closer working relationship with the Department of Psychiatry at OUHSC is in order. This relationship can contribute significantly to both programs.

It has been a privilege to serve as a consultant to the Clinton Service Unit for the past four years. My respect and affection for the Cheyenne-Arapaho people continues to grow. It is time again to express my gratitude to tribal members and staff of the IHS and BIA for their cooperation throughout the year. John Bjork in the area office has provided much helpful guidance and support. My sincere thanks go to him, as well as to members of my department. Special thanks also go to my tolerant and understanding family for their interest and help with this project.

Mary Frances Schottstaedt

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* In the summer of 1974 Dr. Schottstaedt moved to Houston, Texas and is no longer available to IHS.

2. Cheyenne-Arapaho Lodge - Bessie, Oklahoma

This project was initially funded by IHS Mental Health Programs and is now sponsored by the National Institute on Alcohol Abuse and Alcoholism. It is unique in its blending of tribal traditions, the Native American Church, and an Indian adaptation of Alcoholics Anonymous. It combines detoxification functions with backup services from the IHS hospital at Clinton, and the functions of counseling and reintegration into the community often included in Halfway House programs. However, it is more nearly a community in its organization and life style than the usual institutional counterpart of these functions.

Physically, the Cheyenne-Arapaho Lodge is a converted school no longer used for its original purposes since consolidation of rural schools has taken place. There are two large dormitory facilities for men with bathrooms and showers. An adjacent small house provides living quarters for women. In the main building there are kitchen and dining facilities for group meals, a game room, lounge, library and arts and crafts facilities.

Chores are divided among the residents for maintenance and general upkeep. Several residents leave and return daily for part-time employment in nearby towns.

Families and visitors are welcome and included in ongoing activities. However, because of its relatively isolated location, only those with a personal interest come often or stay long at Bessie.

The best way to get a flavor of this program and to see how its details fit together, short of a visit, is to read the program description recently provided by George Hawkins, Director.

"CHEYENNE-ARAPAHO ALCOHOLIC REHABILITATION CENTER PROGRESS REPORT

1. OBJECTIVES

a. To provide an environment, community wide, in which an Indian can become an Indian, adapting the native characteristics, cultures, and values to the larger society.
b. To continue, expand, and improve the detox, treatment, and rehab. programs:

2. PROGRAM

When the residents enter the treatment center, they are informed that the anxieties and tensions of every day living needs are relieved. They will be provided food, shelter, and other necessities. Withing 72 hours they are given a complete physical examination by the Indian Health Service, at the Clinton Hospital, which also offers psychiatric consulation. They then are offered the opportunity to participate in the following activities:

Native American Religion (Peyote Meetings) - Once a month, the Center engages a "Road Chief" as a consultant, and he, with his officers, hold a meeting in a teepee on the Center grounds. The rituals are conducted from sundown till sunrise and are very serious and arduous. It is a pan-Indian religion identifying the Christian Trinity with the Great Spirit of Indian religion and believing in the necessity of worship of God and brotherhood and charity toward all mankind. A feast follows at noon the next day, and the participants of the "meeting", his or her family, relatives and all the community are invited. This seems to be very beneficial to the alcoholic, not only when he participates in the actual rituals, but also from the feast the following day - in which they are being received by caring and loving members of the community.

Tribal Elders - These are also engaged to come in and speak and visit with the residents, emphasizing the true inner-most values of the Indian.

Language Classes - These are held twice weekly. Most of us have lost the ability to speak our native tongue and we are trying to remedy this. This has been accepted with great enthusiasm by the residents.

Hand Games - This is a type of Indian competitive game and is played by two teams, followed by refreshments. The community is invited and a very enjoyable sociable time is experienced. These are held twice monthly.

Therapy and Group discussion periods are held, as indicated on the enclosed "Weekly Schedule." During the morning classes, we sometimes intersperse with our own staff, people from the clergy, lawyers, business people, universities, etc

3. A.A. MEETINGS

Three meetints are offered each week. Monday night is sponsored by the Center and held in the Episcopal Church in Clinton. This is aimed primarily at the inmates of the Clinton City Jail. The Center's residents participate and the coordinators pick up the inmates, returning them after the meeting. Quite often the inmates are receptive to coming into the Center for treatment and working with the cooperation of the police department, they are allowed to participate and the coordinators pick up the inmates, returning them after the meeting. Quite often the inmates are receptive to coming into the Center for treatment and working with the cooperation of the police department, they are allowed to do so.

Wednesday night - This group is composed of the residents in the Center, completely autonomous. The staff attends only as alcoholics.

Thursday night - The residents are offered an opportunity to attend a meeting in Cordell.

Al-Anon - This group meets on Monday nights here at the Lodge, with a group from Cordell conducting the meeting the first Monday of each month, a group from Elk City the second Monday, a group from Clinton the third Monday, and a sponsor connected with the Lodge, the fourth Monday.

Ala-Teen Meetings - Held on the same basis and the same nights as the Al-Anon's.

4. EXCHANGE VISITS AND COMMUNITY PROJECTS

We have been exchanging visits with another Indian Alcoholism Program, located in Anadarko, Oklahoma, engaging in competition at pool, checkers, pitch, dominoes, and ping-pong. We break for and evening festive meal and then an A.A. meeting.

Occupational Therapy - This is directed primarily to getting the individuals interested in something to occupy their leisure time here and when they leave. We have been very fortunate in engaging a person who is very knowledgeable about Indian handicrafts. The residents look forward to her classes. The artifacts that are made give the resident a sense of accomplishment and also to make some spending money, as these artifacts are for sale to visitors. We also participate in the Trade Fairs held in the surrounding towns.

Hospital visits - The coordinators take a group to the IHS Hospital for visits two afternoons a week. All of the residents participate. We think this is good therapy and also creates greater visibility for the Center.

The residents have installed and maintained sanitary facilities for the powwows, and cleaned and refurbished Indian cemeteries in the area.

The residents have also been volunteer blood donors.

A great many of our residents have not had or have lost a family and we are gratified in thinking that we have established a sense of belonging, a family atmosphere. Some of the residents who have left here and gone on to school at Albuquerque (S.I.P.I.) or Oklahoma State Tech in Okmulgee have returned to spend parts of their vacation here.

Some of the other Indian programs have sent their people here for a short indoctrination into the machinations of a rehabilitation center, and seemed to acquire some help. This also makes us feel as if we are making some progress.

The Director was chosen by his fellow Indian confreres to serve on a steering committee to organize an Oklahoma Association on Alcoholism and Alcohol Abuse. We think this is very important; to be able to have an Indian input into an organization of this type, which may have great influence on the direction alcoholism programs are developed and administered here in the state of Oklahoma.

5. TRAINING

The United Indian Recovery Association, Inc., whose membership is made up by staffs of the Indian alcoholism programs from the states of Oklahoma, Kansas, and Texas meet each month at the various program sites, primarily to exchange ideas, problems, and promoting a sense of cohesiveness and cooperation.

The two coordinators on the staff are now enrolled and attending the Western Region Indian Alcoholism Training Center, University of Utah. (12-month course)

The Director and the chairman of the Board of Directors attended a workshop, sponsored by the WRIATC in Albuquerque, New Mexico, July 16-18, 1973, and August 7-10, 1973.

The staff continues to attend various workshops and seminars held in the area, including the first "Oklahoma Conference on Alcoholism and Alcohol Abuse," at the University of Oklahoma.

The Director was one of the 20 participants, gathered from around the nation to fulfil the contract between the Association of Halfway Houses Alcoholism Programs and the NIAAA to "study and determine problems encountered in the growth, financing, standards for operations, and relationships with community resources, as it pertains to half-way house alcoholism programs in the 50 states, District of Columbia, and Puerto Rico." This was training at its best.

The following also could be considered training and community education.

We have instituted, here at the Cheyenne-Arapaho Alcoholic Rehabilitation Center, a monthly workshop, inviting people representing the agencies listed below and all have attended:

Tribal Councilmen
Social Services, PHS Indian Hospital
Mental Health Worker, PHS Indian Hospital
R. N., Indian Hospital
R. N., PHS Indian Area Clinic
Environmental Health, PHS Indian Hospital
Health Educator, Clinton Service Unit
IHS, Community Health Representative
IHS, Maternal Health Aide
Chief, Social Services, IHS Area Office
State Social Worker, D.I.S.R.S.
BIA Social Worker
Area Alcoholism Coordinator, State Dept. of Mental Health, Div. on Alcoholism

State Public Health Nurse
M.D., Ph. D., Dept. of Mental Health, Director of Drug Abuse Div.
Supervisor, Oklahoma City - County Health Clinic (Retired)
Cheyenne-Arapaho Education Program
Tribal Housing Authority
Committee of Concern, Clinton, Oklahoma
3-R Program - Resocialization, Recidivism and Reduction
Clergy
Al-Anon
Alcoholics Anonymous
Native American Center, Oklahoma City, Oklahoma
Staff, Cheyenne-Arapaho Alcoholic Rehabilitation Center

We, at the Center, recognize the premise that people from various disciplines, at the several educational levels are essential, because one individual does not have the full range of expertise to completely cover the variety of problems that the alcoholic patients presents. And also that alcoholism is a family and community problem.

6. IMPORTANT CONSIDERATIONS

Other points we have taken into consideration and which we think very important are:

1. The Indian cultural factor - "the ethic of non-interference in others lives." During the evolvement of the workshop, we considered this very important. No matter how many resources available to the Indians, they are worthless unless he accepts them. So during the workshop we try to determine what individual has a rapport with the alcoholic patient or his family, then all the other "helpers" channel their resources through this "helper" until all "helpers" are accepted.
2. The alcoholic has been lectured, threatened, and promised certain things will happen and when they don't, he will reject all help. In bringing all the resources together and making firm commitments, delegating the chosen "helper" to see that its done, we are carrying out our assignments. The alcoholic can see something tangible happening - getting windows in his house or hot water (these are some of the things that have happened.) This seems to make the alcoholic feel that someone cares and that there is some hope for the future.
3. We feel that this also sensitizes the other agencies to the fact that alcoholism is a community responsibility, not just the alcoholism programs. And that this must be a cooperative effort.

We are very excited about the progress that has been made toward these objectives and the monthly workshops will continue."

CHEYENNE-ARAPAHO LODGE

WEEKLY SCHEDULE

MONDAY

10:30 A.M. - 11:30 A.M.	Total Group Therapy
1:00 P.M. - 3:00 P.M.	Hospital Visits
8:00 P.M. - 9:00 P.M.	A.A. Meeting - Clinton
	Al-Anon Meeting - Lodge
	Alateen Meeting - Lodge

TUESDAY

10:00 A.M. - 11:00 A.M.	Therapy - 2 Groups (1.) Residents under 30 Days. (2.) Residents over 30 Days.
1:00 P.M. - 5:00 P.M.	Occupational Therapy
7:30 P.M. - 8:30 P.M	Language Class

WEDNESDAY

10:00 A.M. - 11:00 A.M.	Therapy - 2 Groups (1.) Residents under 30 Days. (2.) Residents over 30 Days.
1:00 P.M. - 3:00 P.M.	Hospital Visits
	Group Physical Therapy
8:00 P.M. - 9:00 P.M.	A.A. Meeting - Lodge

THURSDAY

10:00 A.M. -10:30 A.M.	Group Discussions
10:30 A.M. - 11:00 A.M.	Small Group Discussions
1:00 P.M. - 5:00 P.M.	Occupational Therapy
8:00 P.M. - 9:00 P.M.	A.A. Meeting - Cordell
7:30 P.M. - 8:30 P.M.	Language Class

FRIDAY

10:00 A.M. - 10:30 A.M.	Group Discussions
10:30 A.M. - 11:00 A.M.	Small Group Discussions
1:00 P.M. - 3:00 P.M.	Group Physical Therapy

SATURDAY -- Free

SUNDAY

11:00 A.M. - 12:00 Noon	Church

STATISTICAL REPORT OF 85 RESIDENTS

June 1, 1973 - February 28, 1974

Age	No. of Residents*
20 and under	3
21-25	4
26-30	16
31-35	14
36-40	11
41-50	15
50 and over	12
Total:	75

Sex	
Female	10
Male	65

Marital Status	
Single	34
Married	11
Separated	11
Divorced	12
Widowed	7

Couples (Husband & Wife) 3

Admissions	
First	54
Second	15
Third	6

Intensive Treatment	
30 Days	57
Less than 30 Days	28

Average Duration - 9 weeks

Education	No. of Residents
8th grade and under	14
9th - 11th grade	35
High School graduate	23
College graduate (one degree)	3

Status When Admitted	
Non-skilled	65
Skilled	6
Professional	1
Retired	3

Placements	
School	12
School to job	2
Job	20
Retired (assisted in processing)	4
Total:	38

Children Dependents With: (age 18 or under)	
Family	4
Spouse	2
Relatives	47
Foster Homes	24
Total:	77

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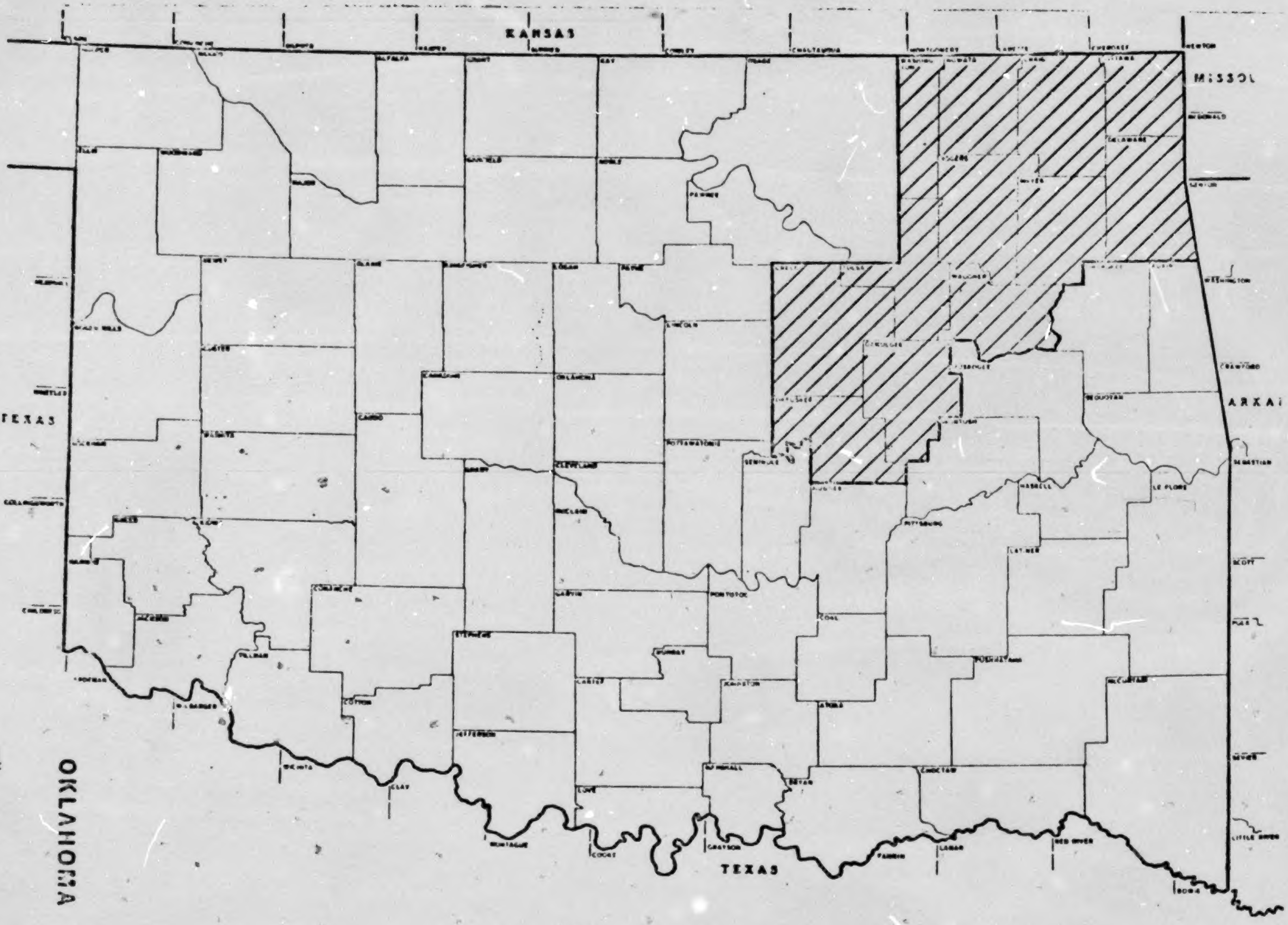
* Ten residents stayed less than 4 days and are not included in the report as we were unable to obtain sufficient history.

Claremore Service Unit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G. Eastern Oklahoma

1. Claremore

Claremore, twenty-seven miles east of Tulsa, was the first program to secure the services of a Mental Health Consultant of Indian descent. Ronald Lewis served both Claremore and Tahlequah starting about 1970. However, he was later accepted at graduate school in Colorado and has been away since 1971-1972 studying for a Doctorate in Social Work.

Vicki Wilkerson, a Mental Health Specialist, has been recruited for the Claremore Hospital and works actively in the community with the various referral resources and with tribal alcohol projects.

The Claremore Indian Hospital serves a large number of tribes, many quite small in numbers, who were settled on or near lands originally assigned to the Cherokee (See map in frontispiece). The Cherokee - Shawnee and the Delaware - Cherokee represent portions of these tribes who contracted alliances with the Cherokee in the early 1900's. There is also an Eastern Shawnee tribal unit which is distinct from both the Cherokee - Shawnee and the Shawnee in central Oklahoma. The Quapaw and the Fuchi are southern woodland tribes. The Seneca - Cayuga and the Wyandott are northeastern woodlands in origin. The Otoe - Missouri and the Miami are from the middle west. In addition, the Claremore Service Unit shares with Tahlequah provision of services to the Cherokee Nation along its northern borders.

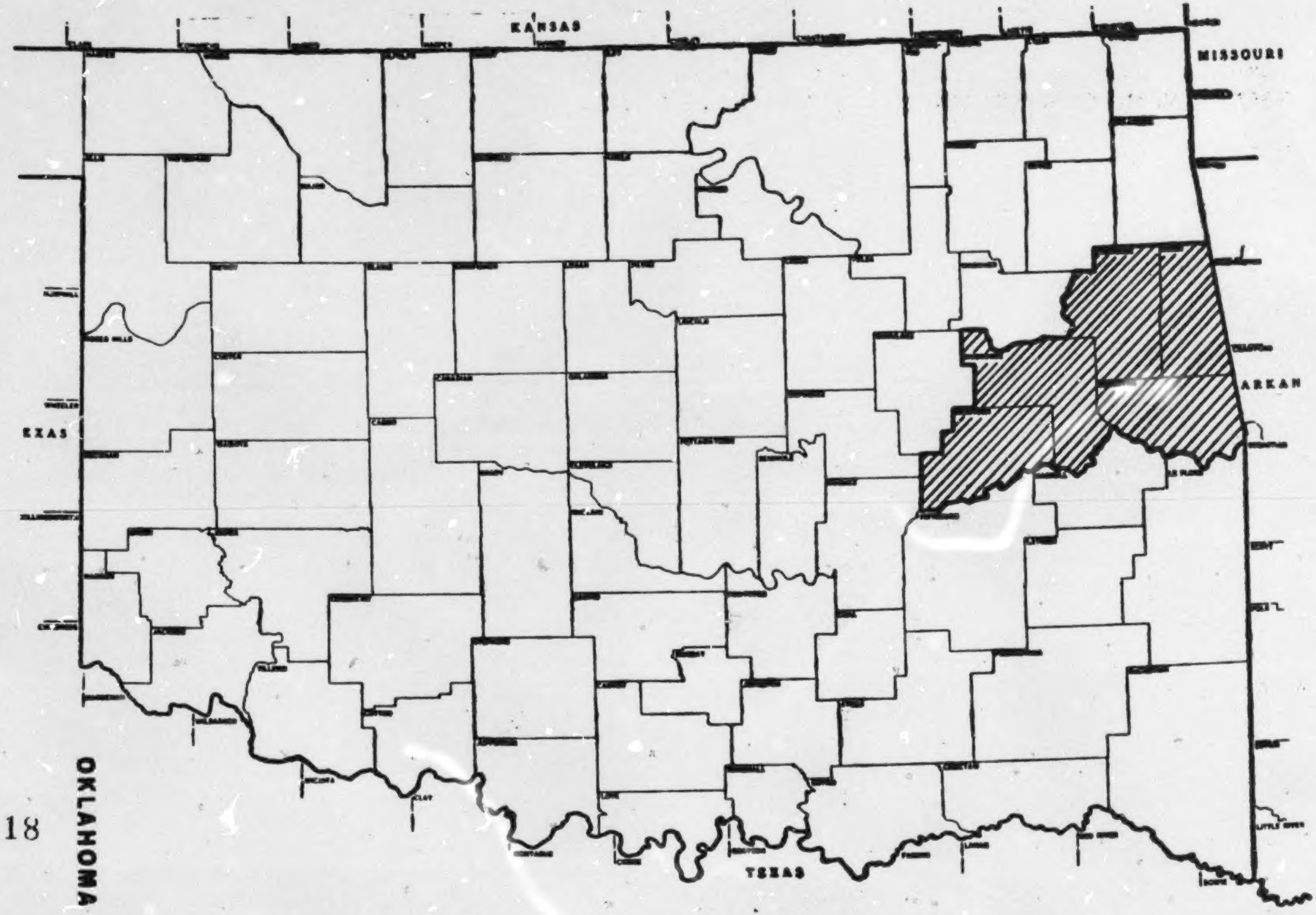
There are six field clinics in addition to the sixty-six bed hospital, and some effort is made to give regular service to each of these. There is also an active health center at the Seneca Indian School at Wyandotte, and regular counseling sessions with students are scheduled there. Miss Wilkerson rides to the various clinics with the physicians from the Claremore Hospital, which both saves transportation costs and also facilitates exchanges of information and planning.

Effort is made to use the resources of Tulsa including Goodwill Industries, Tulsa Psychiatric Foundation (for adults) and Children's Medical Center, as well as the University of Tulsa, which has an active clinical psychology program. However, some of the population to be served lives almost one hundred miles from this city. It is often several hours drive from their homes to the Claremore Hospital as well, so that developing local resources and an increasing ability for IHS staff at a variety of levels to work effectively with human emotional stress and problems is essential.

In the 1974 Annual Report the Claremore Service Unit is described as follows:

> "Mr. Lounsberry only recently joined the staff, but he brings a background of mental health program development, as well as service unit director experience, from his previous assignment in the Dakotas. He was especially active in alcohol and school mental health services.
>
> Ms. Wilkerson has been the main-stay of the program almost from the time of her employment. She has been active in the treatment and referral of patients and in providing direct care to students at Seneca once each week. She visits the Jay Clinic twice monthly and provides consultation to the alcohol halfway house in Miami on request. She has attended several training courses during the year, including the Kathryn Cornell School of Alcohol Studies, the Family Therapy Workshop, and the Community Health Practices Course at Desert Willow Training Center.
>
> Ms. Narcomey has been receptionist and secretary for the Branch at Claremore. She has also assumed some responsibility for joint interviews with Ms. Wilkerson, as well as interviewing selected patients in her absence. Ms. Narcomey's interest in mental health work led to her seeking further training in this field and she is currently attending the ten week Social Work/Psychology Procedures Course at the Academy of Health Sciences, Brooke Army Medical Center, Fort Sam Houston, Texas."

Tahlequah Service Unit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2. Tahlequah

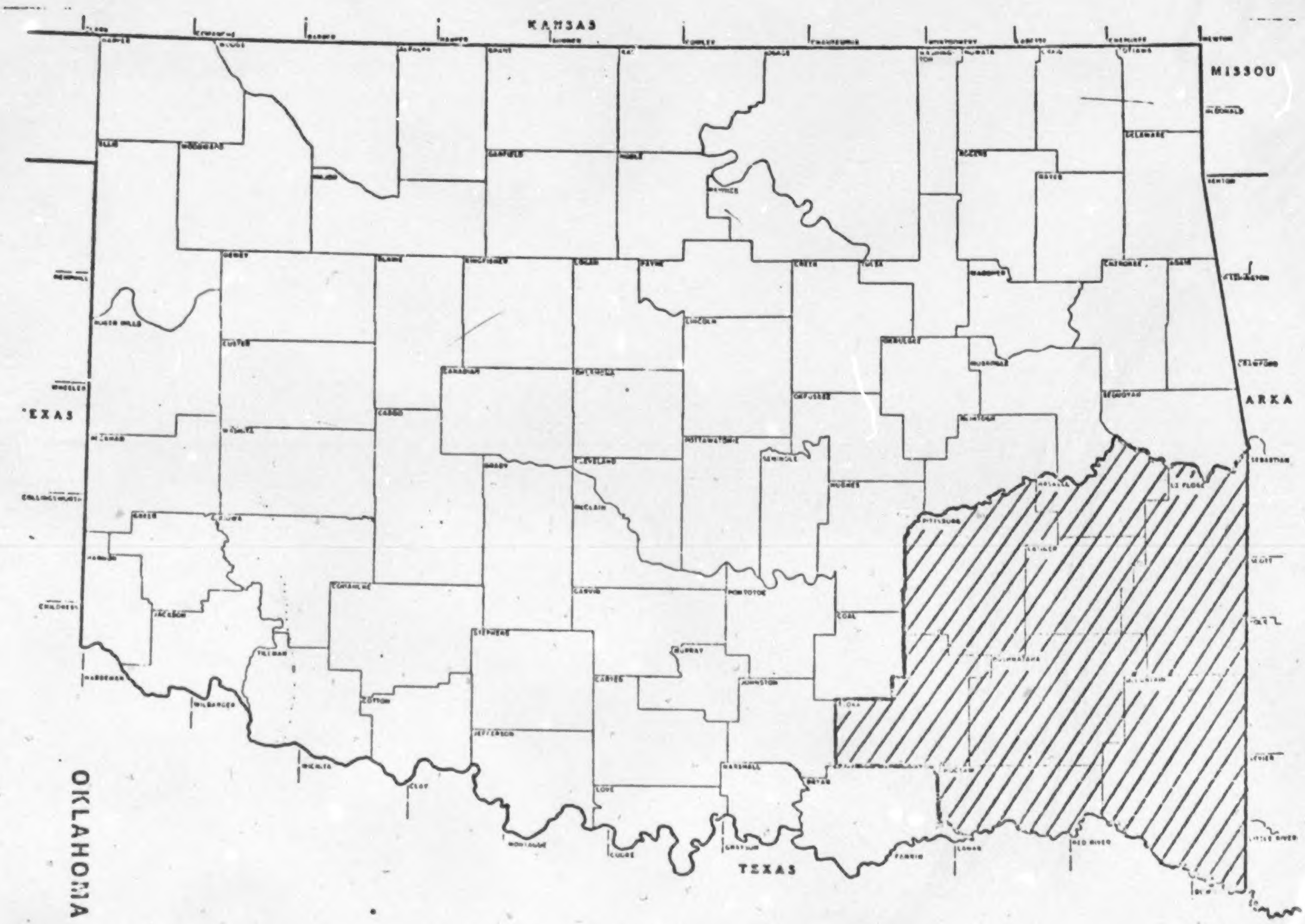
Seventy-five miles south of Tulsa is the Cherokee capital of Tahlequah. It is a community of 9,000 people, located in a recreational area formed from the confluence of three rivers, the Illinois, Grand, and Arkansas. The Cherokee have established a craft center and restaurant, as well as modern tribal offices, and are planning a motel. They have developed a summer pageant on the theme of the "Trail of Tears" as a tourist attraction and means of recounting their own history.

Ties are not too distant to utilize the University of Arkansas as well as the Northeastern State College of Oklahoma. Bacone College, a private institution in Muskogee, has a traditional tie to the Indian community. However, to date little utilization of students or faculty from these institutions as Mental Health manpower has been developed.

The Cherokee Nation and the Creek Nation are both served by the fifty-seven bed accredited hospital, and three field clinics are served once a week. In addition, there are two BIA schools with Health Centers, Sequoyah High School and the Eufala Boarding School. Although this Service Unit has the smallest areas, it serves a population of over 16,000 people, many of whom still speak, and even write in a language other than English.

Mr. Isaac Christie, Mental Health Specialist at Tahlequah, sees approximately thirty individuals per month, about one-third of whom are inpatients in the hospital. He has clinical support through a private psychiatrist in Muskogee and works cooperatively with BIA Social Services. This extensive range of activities is described in the 1974 Annual Area Report as follows:

> "We are hopeful about adding a Mental Health Consultant to the staff in the near future. In the meantime, Mr. Christie will continue to provide the wide range of mental health services he has in the past. In addition to direct patient care, these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Talihina Service Unit

> include case and program consultation and collaboration to a variety of community resources, such as: Cherokee County Guidance Center, Sequoyah, Eufaula, and the public schools, Tribal Alcohol Counselors and CHR's, Cherokee County Delinquency Program, the State Mental Health Clinic, and the Johnson O'Malley Program."

3. Talihina

Immediately south of Tahlequah is Choctaw country, extending through the southeastern section of Oklahoma to the Arkansas-Texas border. This is rugged, scenic country, with Winding Stair Mountains and other branches of the Ozarks. It is sparsely populated, and the ninety-eight bed IHS Hospital is probably the largest health resource to be found in that section of the state. McAlester, Oklahoma is about fifty miles away, Tulsa 150, Oklahoma City 190, Dallas, Texas 200, and Fort Smith, Arkansas a relatively close 72 miles. All of these distances are through mountainous terrain, and require more than the average allowance of time for travel by private car. There is no public transportation system, although some interstate bus service is available between major points.

Talihina Indian Hospital was the last unit specializing in TB in Oklahoma. As the need for many beds has decreased with the reduction of the tuberculosis rate and improved methods of treatment, some thought has been given to utilizing part of the Talihina Hospital for an inpatient facility. Primarily because of the space available, it offered the most feasible opportunity to demonstrate the practicality of using Area IHS hospitals more imaginatively for the care of patients with emotional disorders. Dr. Jorge Ferriz, a psychiatrist, was recruited with this in mind. He developed a small but adequate unit for brief hospitalization - a "cooling off period" - and made these services available on a limited basis to Tishomingo and Tahlequah as well.

Unfortunately, Dr. Ferris left for Alaska and a nursing shortage combined with lack of a medical background made his replacement, Mr. Tim Nolan, M.S., a psychologist, understandably reluctant to accept patients from out of his Service Unit. Instead the space has been expanded and re-equipped to serve as a day care program for the disturbed. As such it also can offer to a wide range of general hospital patients the occupational therapy and recreational activities in the program.

In addition the staff at Talihina carries on activities very similar to those of other Service Unit Programs. One of the monthly reports from this unit describes these activities in detail and is included here as an example of programs staffed by disciplines other than psychiatry.

Floyd Anderson, SUD
PHS Indian Hospital
Talihina, Ok 74571

November 5, 1973

Tim Nolan, Psychologist
Chief, Mental Health Department

Monthly Narrative : October 1973

Mental Health Activities:

Administrative Functions
  Medical Staff Meetings-3
  Dept. Head Meetings-4
  Mental Health Committee-1
  Health Board Meeting-1

Mental Health Highlights

1. Six patients were admitted for residential treatment and therapy. The admissions were based on: psychotic symptoms, suicidal ideation, emotional fatigue, and anxiety reaction due to marital turmoil.

2. Marital counseling was the major presenting problem for out-patient theraputic contacts. The total number of significant patient visits during the month was 36.

3. Mr. Nolan was on annual leave during the week of October 7th to the 13th.

4. On Thursday October 4, Mr. Nolan attended a workshop on finance conducted by members of the area office staff at the Talihina Service Unit. As a result of attending at that workshop a much greater appreciation of the complexities and procedural channels involved in -- the IHS financial management, budget and procurement systems was realized.

5. The Mental Health Team attended a meeting of the Mental Health Committee on October 16. Phil Harjo organized the meeting and explained the duties, function, and purpose of the committee.

6. On October 17, an inpatient review system was put into effect and is referred to as "chart rounds". Representation from medical, nursing, dietary, public health nursing, pharmacy, social services, and the mental health department participated in a weekly review of the current inpatient population. The purpose of chart rounds is to maximize and coordinate services among those departments with most patient contact for the benefit of the individual patients.

(cont)

7. Mr. Nolan attended the Health Board Meeting on October 17th during which Mr. Phil Harjo, the Mental Health Educator for the area, discussed the program conducted by his office.

8. Mr. Nolan participated in the Defensive Driving course conducted at the Talihina Service Unit by safety officer, Toby Wise, which began on Octobe and consisted of four two hour sessions.

9. On October 18, Miss McAllister and Mr. Nolan had a film showing and discussion for the Community Health Representatives at the Clubhouse. The discussion centered around the films: "Emotional Factors in General Practice: Their Recognition and Management", and "Free-Expression Painting in Child Psychiatry".

During the session, the CHRs were requested to return an informational questionaire to Mr. Jack Impson as soon as possible. The questionaire was developed by Ms. McAllister and asked the following questions:

a). What services do the Mental Health Department at the Talihina Indian Hospital provide?

b). How could we work best with the Mental Health Team?

c). What is your interest in Mental Health?

d). What services can the Mental Health Department provide for the CHRs?

10. The Psychologist and Pharmacist from Talihina Hospital attended a community meeting on October 18 at Daisy, Oklahoma, at the request of Albert Cooper, CHR. The meeting centered on a discussion of the Mental Health and Pharmacy programs at the hospital.

11. Dr. Alfonso Paredes from the State Mental Health office, division on Alcoholism was guest lecturer at the medical staff meeting on Oct. 19th at the invitation of the Mental Health Department. Dr. Paredes has a particular personal interest in Alcoholism among the Indian people and has been involved in research in this area for several years.

12. On October 20th the pool table was assembled and the recreational therapy room will be in operation when the dental supplies are moved from the area.

13. Mr. Bob Nelson, a counselor from the Carter County Guidance Clinic located in Ardmore, Oklahoma, visited the Mental Health Team on October 30 to discuss the availability of treatment programs for the non-veteran Indian alcoholic that are involved in his program. The limits of our program in regard to residential alcohol treatment were explained to Mr. Nelson. Information about half way houses and state institutional treatment programs were discussed.

Page 3 (cont)

Field Trips:

1. On October 1st, the Mental Health Team met with the Jones Academy social service personnel to further evaluate the needs of the academy and how the Mental Health Team's services can be rendered.

2. Ms. McAllister met with Jack Impson, CHR Coordinator, to familiarize him with the services the Mental Health Team now provides, and to reestablish our relationship with the tribal organization. Miss McAllister gave Mr. Impson a questionaire to be mailed to each CHR. This questionaire would help to understand the basic need for training of the CHRs in Mental Health, Familiarizing them with services and agencies accessible to their people, and to learn what each CHR's interest is in relation to Mental Health.

3. On October 9th, Miss McAllister visited the Broken Bow Health Clinic, First Step House, Kiamichi Youth Center, and Jack Harris, Social Worker Consultant for the McAlester Guidance Center.

a). First-Step House (Alcoholics) Idabel, Oklahoma
Purpose: To learn more about the function and purpose of this particular half-way house, and how referrals might be sent to them.

Accomplishments: Met with Mr. Arthur Crawford, Counselor, at the treatment facility and learned about the AA philosophy behind their treatment program, patient capacity of 12, $25.00 room & board fee after 5 days in the program, patient's involvement in the community, each patient is required to work at the ironworks factory in Idabel, source of funding their program, etc.

b). Kiamichi Youth Center, Idabel, Oklahoma
Purpose: Recieve a tour of this center which is in the process of being remodeled by volunteers from the school system and contacting agencies. This center is to be used for short term counseling for law offenders, runaways, problem children, etc.
Accomplished purpose.

4. On October 15th, Mr. Nolan and Miss McAllister met with a group of 4th, 5th, and 6th grade girls who were referred by Mr. Gary Martin after the girls ran away from the Academy.

5. On October 25th, Mr Nolan attended a seminar on "Alcohol and Indistry and Government" in Tulsa, Oklahoma, sponsored by the Tulsa Council on Alcoholism.
Purpose: To gain a better understanding of the alcoholic employee, how to recognize him and what treatment programs had been established that are successful.
Accomplishments:
a). The conference emphasized the disease concept of alcoholism and the view

that it is a treatable illness.

b). Fonty-five percent of the alcoholics in the United States are not unstable bums, but responsible job holders with ten years senority.

c). Immediate supervisors of an alcoholic are key persons to aid in early identification and treatment, but often times supervisors cover up and hides the alcoholics' problems.

d). Several Oklahoma Oil Companies have: (1). established insurance programs which include medical treatment for alcohol and drug abusers. (2). Counseling programs for the alcoholic employee, which include leave of absence for employee which involved in treatment. Vacant position is held open for the employee to return to if he will seek treatment. Thir is good business both from the humanistic viewpoint and saves the companies money in the long-term.

e). Administrators in governmental agencies as well as industry need to be more informed about recognition and treatment for the alcoholic employee.

(1). The State Mental Health Department have two resource people who travel the state and present information about implementation of programs for industrial alcoholism problems.

(2). John Bjork, IHS Area Mental Health Consultant, has tentative plans for working with Dwight Brainard, one of the state resource counselors, within Oklahoma Service Units, if the service units request such assistance.

6. October 29th, Mr. Nolan went to Jones Academy, Hartshorne, Oklahoma.
Purpose: Consultation every 2 weeks

Accomplishments:

a). Session with several students experiencing adjustment difficulties.

b). Meeting with dorm director, Dorothy Spears concerning individual student difficulties, and staff communication.

Tim Nolan

Tim Nolan, Psychologist
Chief, Mental Health Department"

"Floyd Anderson, SUD
PHS Indian Hospital
Talihina, Ok
Tim Nolan, Psychologist
Mental Health Dept.

November 5, 1973

Field Trip not included in Monthly Narrative

DATE: October 23, 1973

PLACE: Talihina Head Start Child Development Center
Talihina, Oklahoma

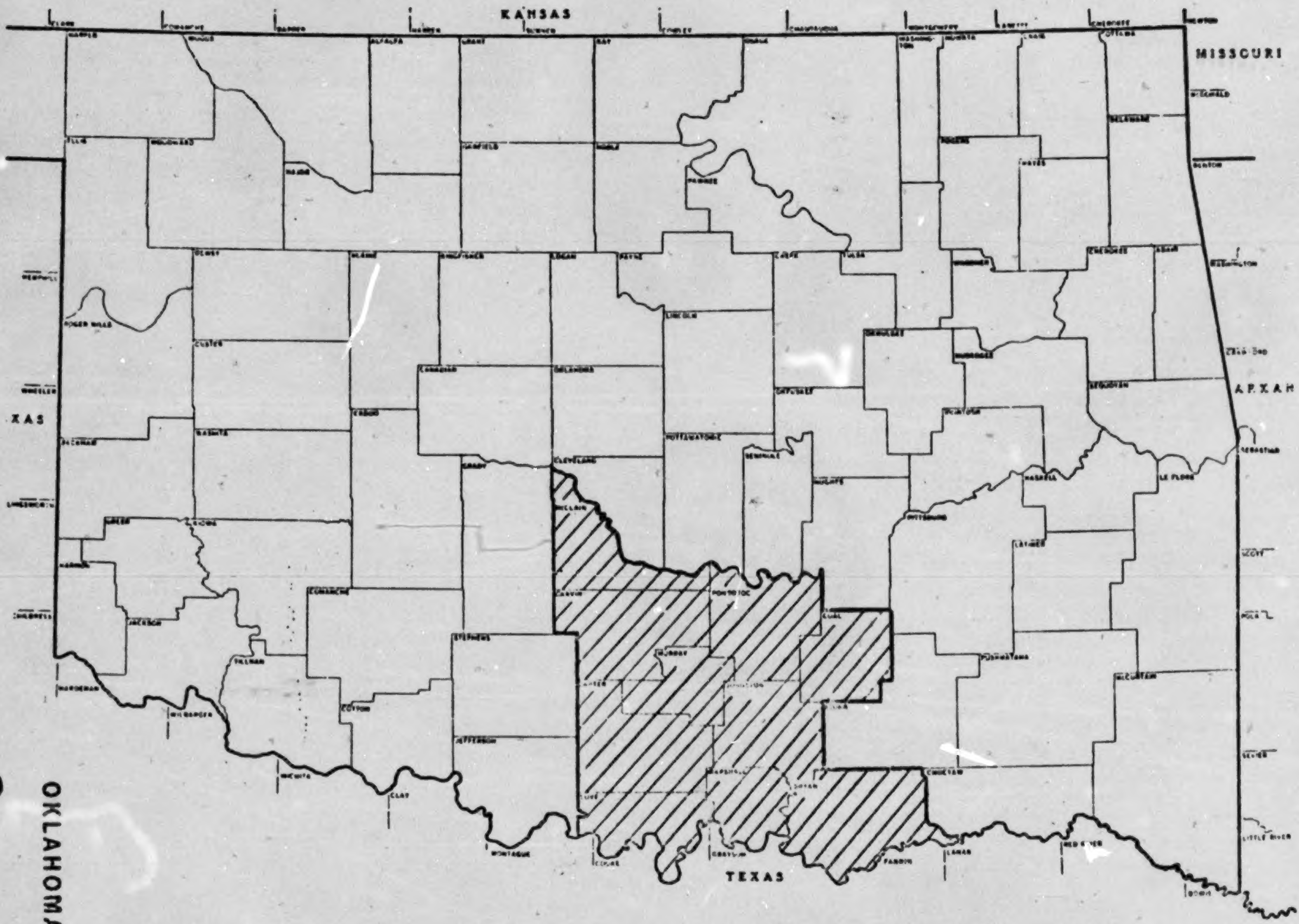
On October 23, 1973, Ms. McAllister met with Joy Roye, Head Start Director for Haskell, Latimer, Pittsburg, and Leflore County, at the Talihina Head Start Center. Ms. Roye explored the possibility of using the Mental Health Technician at the Talihina Indian Hospital for psychological testing. This testing would be a screening device for all children who are Indian that should be referred to the McAlester Guidance for further testing and counseling. There has been some need for referring children to the McAlester Guidance Center and a "professional" is required to observe the child first.

Tim Nolan, Psychologist
Chief, Mental Health Department"

In the annual report for 1973-1974 previously cited, the Talihina Service Unit Mental Health Program is summarized as follows:

> "The Mental Health program has taken advantage of the space available in the hospital to develop recreational and occupational therapy services for patients. Both staff members have provided direct patient care to in-patients (short term care) and out-patients. Both have been active throughout the year in visiting local and state resources for Talihina patients. They provide patient and program consultation to Jones Academy, the public schools, and the Headstart program. Both recently received training in Transactional Analysis and Mr. Nolan is providing Transactional Analysis in-service training to hospital department heads."

Tishomingo Service Unit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OKLAHOMA

4. Tishomingo

The Tishomingo Service Unit in southern Oklahoma serves the Chickasaw Nation of the Five Civilized Tribes (except for that portion of the tribe who live within the district served by Talihina). It does not include a hospital, but instead utilizes the hospitals at Talihina and Lawton as needed. There is a Health Center at Tishomingo, a Health Station at Coalgate and a School Health Station at Carter Seminary, a BIA boarding facility for students attending school at Ardmore, Oklahoma.

The counties served are like their neighbors in having lakes, wild life refuges and much outdoor recreation. Unlike the country to the east, the terrain is more gentle, and a two hour drive will enable residents to reach either Dallas or Oklahoma City with ease. There is a two year college at Tishomingo, and one at Ardmore, and there are four year state colleges at Durant and Ada.

In addition to the Mental Health Consultant who is a Social Worker, there is also a Mental Health Specialist at Tishomingo. As contract funds are available, H. C. Townsley, M. D., has become available as a psychiatric consultant on a monthly basis since the fall of 1973. Dr. Townsley, who lives in

Norman, is himself a member of the Chickasaw Tribe, and is at present active in state Mental Health program planning and and service delivery.*

Other health facilities are fairly adequate and a considerable part of the activity of the Mental Health team is coordination with these resources. The highlights of their past year's work are given in the Area Annual Report as follows:

> "Mr. Day provides direct patient care services. The Tishomingo Mental Health Committee has been an active one and both staff members have worked closely with it. Mr. Day is a board member of newly formed Ten County Mental Health Task Force of the Southern Oklahoma Development Association. Mr. Day received Drug Abuse Training this year and has encouraged community action projects and public schools to take advantage of Office of Education funds for school-based drug-abuse training teams.
>
> Ms. Roller also provides direct care to patients. She has helped develop the potential of the Mental Health Committee. Ms. Roller has received a positive response from a group of girls with disciplinary problems at Carter Seminary. She works with them each Friday.
>
> Dr. Townsley, a Chickasaw psychiatrist with the State Mental Health Department, has provided consultation and patient evaluations at Tishomingo on a monthly schedule since October."

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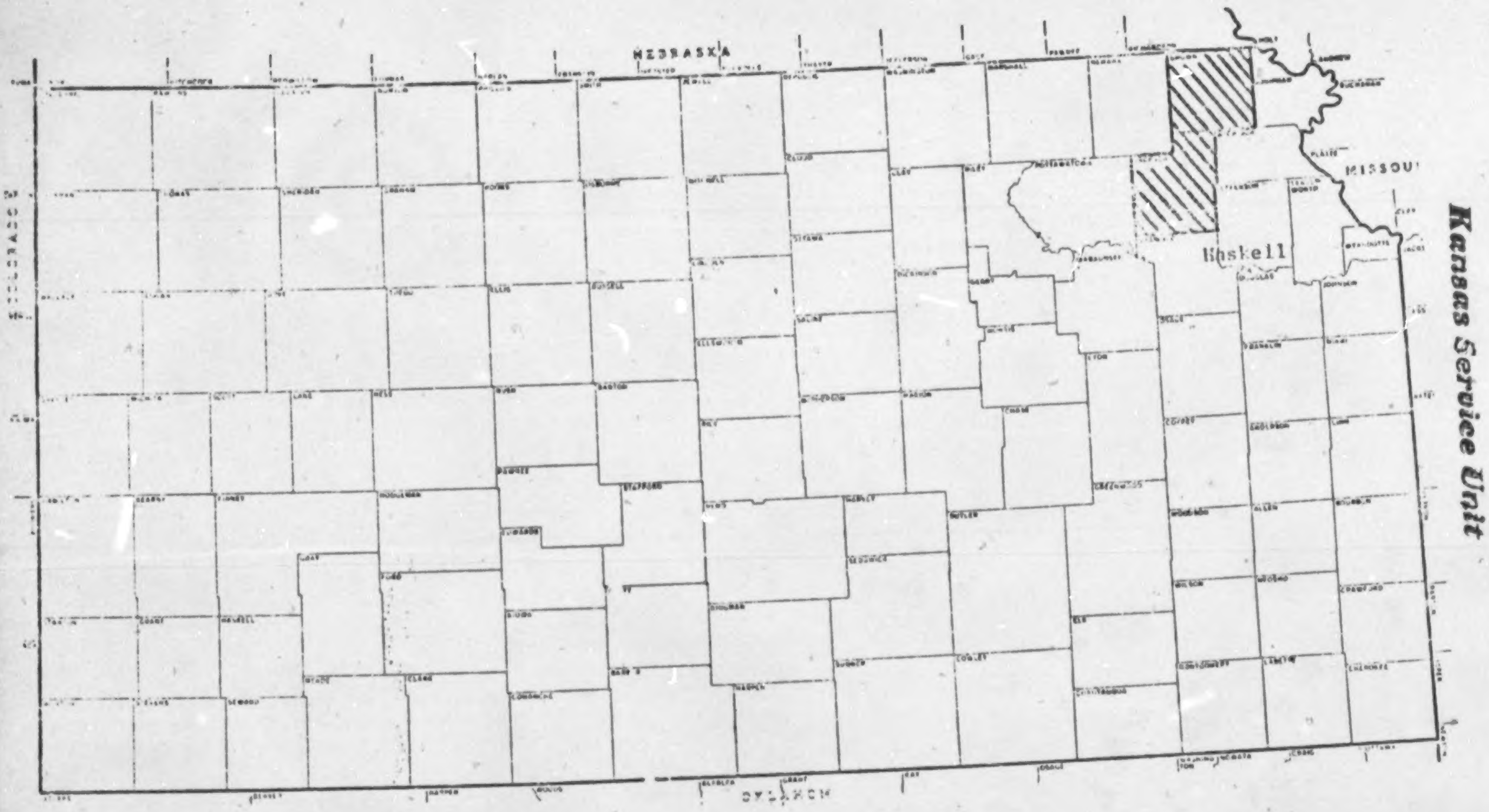
* In July 1975 Dr. Townsley will replace Dr. Bergman as Chief of IHS Mental Health Services and be officed in Albuquerque, New Mexico.

Kansas Service Unit


NEBRASKA
MISSOURI
Haskell
COLORADO
OKLAHOMA

KANSAS

H. Kansas Service Unit - Reservations and Haskell College

Until July, 1973, there had been no Mental Health staff from IHS stationed in Kansas. Referrals for diagnostic and treatment services had been made over the years to a variety of local resources, including Dr. Edward Greenwood of the Menninger Foundation who has a long standing interest in Indian youth, to Topeka State Hospital, and to local community organizations in Lawrence. The BIA in developing its programs at the Haskell Institute has established a separate men's dormitory for students with drinking problems. In other ways dormitory counseling staff and procedures developed for other BIA schools at the secondary level are extended and sometimes modified for the college level student body.

In the summer of 1973 James Bonnar, III, M.D., was entering the experience phase of his program under the NIMH Mental Health Career Development Program. He was recruited and assigned full time as a regular member of the IHS Health Center located on the campus of Haskell. Dr. Bonnar had just completed his psychiatric residency at Massachusetts Mental Health Center in Boston, but was no newcomer to IHS. Before undertaking his specialty studies he had served as General Medical Officer and SUD at Fort Yates, North Dakota. The intensive and extensive involvement with the BIA school system is, however, new for both Dr. Bonnar and for the Haskell staff. The interagency relationship at Haskell, as everywhere, is a delicate one since IHS services are essentially external to the administration of the school itself. Yet mental health services interact with all aspects of school life. Cooperative working relationships are essential if the students are to be assisted in their growth and development, and staff need similar support if they are to risk changes and attempt preventive as well as treatment programs.

Dr. Bonnar elected to emphasize his role as fostering Mental Health rather than as a person who only treated those who were "ill" or "crazy." This stance has enabled him to establish working relationships with students through group sessions, and with staff as a resource person interested in facilitating their goals for students. He established several opportunities for discussing mental health concepts and for group discussions of social and emotional growth. Contact was made in class settings, in dormitory rap sessions, and at community activities rather than being limited to referrals through the medical and administrative channels. In this activity he has worked closely with Mrs. Dukelow, P.H.N., who as school outreach nurse has developed programs for the women's dormitory in parallel with Dr. Bonnar's work in the men's dorms.

Dr. Bonnar has actively sought out links with not only the professional resources in the vicinity (Menninger Foundation, Topeka State Hospital, etc.), but also community groups such as local Indian clubs and church sponsored young adult groups in which Haskell students participate. There is a fair percentage of Haskell students who are married and who live off campus. They can often be reached more easily and assisted through these contacts than in campus limited projects. Those students who are members of the dormitory group are encouraged to take advantage of these opportunities to extend their activities into the community. In addition to work with students, Dr. Bonnar has functioned as a resource for IHS staff and BIA personnel in dealing with their own problems. As well as accepting referrals from the usual interagency channels, he has established contact with community colleges and other institutions in the area who have Indian students or clientele.

Approximately twenty individual and family clients were seen each week in problem solving, crisis intervention and therapeutic sessions in the first half of his tour of duty.

One day a week Dr. Bonner extends his consultation services to the Service Unit at Holton, where he has begun developing relationships with the Kickapoo-Iowa Reservation communities through meeting with their CHR and Health Advisory Boards as well as seeing individual patients. The Sac and Fox Potawatomi Reservation is an hour's further drive, and has access to the Hiawatha Community Mental Health Center facilities, so that except for liaison work with that facility, he had not extended his contacts to the second reservation within this Service Unit as intensely during his first few months.

The needs and services available to the Reservation population are being explored simultaneously with the needs of the students, and Dr. Bonnar's prior reservation experience stands in good stead. This division of activities would otherwise impose rather severe strains in many ways because of the contacts between the rather remote, rural settings and the campus. Plans for the future include recruiting and training a Mental Health technician who would be able to extend services as well as provide clerical and receptionist support for both programs.

III. Development of Special Mental Health Positions

A. Mental Health Educator

In the original plan for developing Mental Health programs for the Oklahoma City Area, both Dr. Meyer and Dr. Gordon felt that there would be a role for a person of a high level of social organization who would represent the Indian constituency of the Area. It was felt that such a person could be selected by the Indian Health Advisory Boards and would coordinate acitvities with tribal needs and expressed desires. After two years of coordinated effort, the qualifications for this position were better understood and shared between the IHS Mental Health Area staff and the Health Advisory Board. Such a post requires someone who is skillful at establishing rapport with community groups, familiar with mental health principles and concepts, and who is able to chair discussions, select appropriate films, and provide from resources or develop locally applicable training and community education materials. A definite agreement as to administrative and technical supervision has been drawn up, including arrangements for IHS training and on the job supervision during the early employment period, as has been discussed earlier on page 42. The mechanisms for interrelationships with the Indian Advisory Board are an administrative model which may prove valuable in other Areas. Since this position is apparently unique within IHS Mental Health programs, the job description is quoted in full, and the usefulness of this tupe of additional staff will be watched with interest.

"OKLAHOMA CITY AREA

PROPOSAL FOR A MENTAL HEALTH EDUCATION PROGRAM

Background

The program report and plan for Indian Health, Fiscal Years 1971-1975, lists Mental Health as a project priority second only to the provisions of training for increased numbers of Community Health Representatives and Native Health Aides. One of the major goals of the Indian Health Service in Fiscal Year 1974 is to continue Tribal involvement at the level desired by Indian people and provide better consultation to strengthen management of Tribal Health Programs. Through a contractural arrangement with the Oklahoma City Area Indian Health Service Advisory Board, this proposal will provide a comprehensive mental health education program to Indian consumers and providers of health care.

Purpose, Scope, and Method

One of the five essential services of a comprehensive community mental health program is to provide consultation and education. Mental health education services are needed to promote mental health and prevent mental illness. The primary goal of mental health education is to promote positive mental health by helping people acquire knowledge, attitudes, and behavior patterns that will foster and maintain their mental well-being.

The scope and method of the mental health education program are outlined below in a program plan format with five objectives and accompanying milestones by which the Mental Health Educator may expect to reach the objectives. As the educator becomes knowledgeable and proficient in accomplishing the objectives, they may be used as guidelines for the activities of the committees, as well.

Objective and Operating Plan, FY 74, of the Mental Health Education Program

Objective No. 1: To plan, initiate, and implement a mental health public information service.

Milestones

1. Identify mental health information needs, problems, interests, priorities and target groups of Indian people with the help of the mental health committees and others.

2. Develop mental health information directly and through the committees and others in accord with findings above.

3. Organize and operate an informational service to provide answers to inquirie to the Area Board. For example, organize a speaker's bureau composed of mental health committee members. The goal is to create awareness in the public with the expectation that the knowledge will help people be more receptive toward attitude and behavior change.

4. Provide mental health information directly and through the committees to students of all ages and assist learning institutions (BIA and public schools with a substantial proportion of Indian students) to develop mental health information programs, for example, promote mental health during mental health week at health career fairs and pow-wows.

5. Provide the foregoing services to non-Indian or mixed publics so that information about the special mental health information needs of Indian people is widely disseminated, understood, and acted upon.

Objective No. 2: To plan, initiate, and implement a mental health educational resource service for special target groups of Indian people, such as mental health committees, Community Health Representatives, other Indian and non-Indian caretakers, Indian families and students.

Milestones

1. Help identify mental health education needs, problems, interests, priorities and special target groups of Indian people with the help of the mental health committees and others.

2. Help develop through collaboration with others mental health education services according to the need as identified above. The goal is to educate and train with the expectation that the knowledge will change the attitudes and behavior of those trained. Forexample, special mental health workshops might be developed for teachers on the significance of behavior in the classroom; interviewing techniques for community health representatives;

child care principles for dormitory aides; referral resources and grantsmanship for mental health committees; human growth and development (including sex education) for students of all ages; child rearing for young couples; training for volunteers; and seminars for agency and instutional staff on the special mental health needs of Indian people.

Objective No. 3: To plan, initiate, and implement a mental health referral service to enable patients, their families and friends, to locate a source of treatment consistent with their need.

Milestones

1. Help identify existing mental health resources in the Oklahoma City Area of the Indian Health Service.
2. Help mental health committee members and others become knowledgeable about resources within their service unit and state.
3. Publicize the availability of committee members and others to be helpful to Indian people, community agencies, and voluntary associations in locating appropriate resources to meet the needs of Indian people for prevention, treatment, and rehabilitation.

Objective No. 4: To plan, initiate, and implement a social action service to mobilize citizen support for improved mental health programs through legislative and program recommendations and the development of special projects.

Milestones

1. Mobilize involvement of committees and others in mental health programs to ensure that existing services are relevant, accessible, and utilized, and that gaps in services are identified and corrected. This includes encouraging Indian people to become active in mental health agency boards and inter-agency councils and providing input in program planning activities of agencies and institutions such as the Indian Health Service, Bureau of Indian Affairs, and state and local governmental and private resources..
2. Mobilize the support of committees and others for the prevention, treatment, and rehabilitation of mental health problems when existing agencies cannot meet the need. Many of these services can be (and are) provided by Indian people. They include, but are not limited to, half-way houses for persons with addiction problems, ex-mental patients, and juvenile delinquents; nursing homes for the elderly; homemaker services; sheltered workshops; juvenile holding facilities; and multi-purpose community centers. Tribal groups can be encouraged to develop such projects and supported in their efforts to secure grants, contracts, and other forms of funding.

Objective No. 5: To plan, initiate, and implement a volunteer service to promote mental health and serve the mentally ill.

Milestones

1. Work toward integrating the work of mental health committees and existing local Oklahoma Mental Health Association chapters (and establishing new ones as needed) to promote the concept of voluntary service to the community.

2. Work with committees, IHS staff, and others to identify the need for volunteer services in the community.

3. Encourage committee members and others to help establish and participate in volunteer services."

"Oklahoma City Area Indian Health Service Advisory Board
Job Description: Mental Health Educator

A. Purpose

The purpose of this position is to provide mental health education services to Indian consumers and providers of health care within the jurisdiction of the Oklahoma City Area Indian Health Service Advisory Board.

B. Major Duties

1. Plans, organizes, and, directs a comprehensive program of mental health education to meet adequately the needs of the area served.

2. Helps tribal groups establish, train, direct, implement, and coordinate the activities of mental health and mental health-related committees through which many of the objectives of the mental health education program will be reduced.

3. Analyzes present knowledge, interests, beliefs, and pra[illegible] of the Indian people in terms of aids or barriers to the educational process.

4. Studies, surveys, and assesses mental health education needs, problems, and possibilities and helps establish priorities.

5. Interprets to Indian people and various community agencies mental health information needs of Indian people which will help the Indian population's capacity to develop satisfying relationships and roles for themselves in their everyday lives.

6. Plans, organizes, and directs an informational service to provide answers to inquiries, and explores and pursues all avenues of desirable information-education-public relations

7. Prepares, selects and distributes informational materials and aids.

8. Aids in stimulating and assisting the mental health education activities of staff of various agencies (i.e., IHS Mental Health and Health Education Branches, and BIA Education Branches).

9. Plans, organizes, guides, and participates in study groups, conferences, workshops, seminars, meetings and similar educational experiences for lay and professional groups.

10. Assists in establishing and maintaining close, cooperative working relationships between agencies which may contribute to improved mental health services to Indian people.

11. Plans, develops, and coordinates a mental health referral service utilizing the organizational structure of the mental health committees.

Mental Health Educator

12. Interprets to Indian people the objectives and services of various mental health resources.

13. Participates in community efforts designed to modify social conditions and systems which are not conducive to positive mental health of Indian people.

14. Stimulates and participates in the development of project proposals to meet the needs of Indian people when gaps in services have been identified.

15. Helps plan and develop volunteer services to aid mental health programs and the mentally ill.

16. Stimulates mental health committee members and others to participate in on-going programs as volunteers to work with all ages of Indian people to promote mental health.

17. Develops efficient records and reports of mental health education activities to facilitate the quantitative and qualitative analysis, evaulation, and interpretation of the education program.

C. Controls and Responsibility

The Mental Health Educator is under the administrative supervision of the Executive Director of the Oklahoma City Area Indian Health Service Advisory Board and receives technical guidance and advice from the Chief, Mental Health Branch, Oklahoma City Area Indian Health Service. The position requires considerable initiative, originality, and judgment on the part of the incumbent. Particularly during the first year, the position should be looked upon as a trainee position in community mental health education.

D. Physical Effort and Working Conditions

The Mental Health Educator will be expected to travel frequently to Indian communities within Oklahoma and Kansas and to participate in numerous evening and week-end meetings."

B. Clerk As Entry To Mental Health Worker Position

As an entry position, and as an answer to the need for clerical support for the Mental Health programs, an especially described entry level position has been developed in one or two of the Service Units. The individual is recruited and hired for a combination of present and potential skills. Initial primary responsibility is clerical, with typing, filing, and receptionist duties assigned. However, a portion of the time each week is devoted to supervised training experience in the functions of a Mental Health Specialist. At an appropriate time formal training is arranged, usually through the Clinical Specialist Program at Fort Sam Houston.

As skills are developed in Mental Health applications, the clerk can be promoted to the level of Mental Health Specialist, and another person entered into the system. This extension of the career lattice provides a realistic entry level position and also permits continuity of development as both staff and program grow together. It also provides critically needed clerical support and ensures familiarity with administrative needs for files and reports at all levels.

IV. Overview of Oklahoma City Area Mental Health Programs

A. Area Office

Between 1969 and January, 1974, the growth of the Mental Health programs in the Oklahoma City Area has been characterized by staff expansion and decentralized operations. In its initial years there was a two-pronged focus of delivering clinical services at the Service Units and of developing interest and awareness amongst the thirty-seven Oklahoma tribal groups served by the IHS. This has now been expanded to include interagency relationships and the initiation of work toward building viable networks of service delivery in Mental Health.

This shift is reflected in the Annual Report for 1973-1974, which describes the activities of the Area Chief of Mental Health Programs:

"To: Assistant Area Director for Program Services
Oklahoma City Area Indian Health Service

From: Chief, Mental Health Branch
Oklahoma City Area Indian Health Service

Subject: Highlights of Mental Health Program Activities, Fiscal Year 1974

Introduction

This report provides summary data about Mental Health Branch activities for the specific use of Tribal Leaders attending the Tribal Leaders' Training Session in the Area Office, May 17 and 18, 1974. In keeping with the assignment, the report offers Tribal Leaders highlights of information about current activities. As such, it cannot provide the kind of information often found in more comprehesive annual reports, i.e., historical perspective, in-depth description of program philosophy or services, assessment of accomplishment, nor detailed future plans. Nevertheless, we hope the report will interest the Tribal Leaders in becoming more involved in the mental health program in their respective areas.

Mr. John Bjork, ACSW, as Chief of Mental Health Programs, directs all aspects of the Area Mental Health program. Activities this year included:

(1) The revising of the Oklahoma City Area IHS Health Advisory Board contract to include a one year trainee relationship to the Branch Chief for the Mental Health Educator selected in March
(2) The developing of an IHS contract with the United Indian Recovery Program of Oklahoma, Kansas and Texas
(3) Developing, with the Cheyenne and Arapaho Tribe and an OU Professor of Psychiatry and IHS Consultant, a grant proposal to the National Institute on Drug Abuse for Concho School
(4) Agreeing to serve on the Board of Directors of that project, as well as the proposal submitted to the National Institute of Mental Health to develop an all-Indian ward at Central State Hospital, if funded
(5) Serving as IHS Chairman of the BIA-IHS School Health Committee; serving on task forces and committees of the Mental Health Division of the Area-Wide Health Planning Organization and the Oklahoma County Association for Mental Health
(6) Developing evaluation information for the OCAIHS Health Advisory Board and the American Psychiatric Association Task Force-Harvard School of Health
(7) Serving as a panel member on the subject Preliminary Assessment of Indian Mental Health Programs and Planning for the Future at the 51st Annual Meeting of the American Orthopsychiatric Association.

> Mrs. Ahkeahbo provides receptionist and secretarial services for the Branch. She has developed a close working relationship with all Branch staff as well as many others with whom the Branch has collaborative relationships. Helping to keep the computerized data forms accurate and on schedule is one of Mrs. Ahkeahbo's special accomplishments."

B. Service Unit Staff and Activities

1. Stability of Personnel

After its introduction in 1969, both IHS staff at the Service Unit level and the consumer tribal groups placed an increasing value on the clinical and consultation skills offered through the Mental Health Programs. Local development has been rapid. A goal was set to staff each Service Unit with at least two staff members, one a professional with at least Master's degree level training and one a local Indian paraprofessional. This goal had been reached in all but one Service Unit by the spring of 1974.

A careful scrutiny of the personnel record also indicates that the Oklahoma City Area has unusual stability. Most personnel have remained on the job at the Service Unit and staff turnover has not been a problem compared with other IHS Areas. Those who have left have, in general, entered advanced training programs or been in a training status while at the Service Unit.

The one discipline where there has not been continuity of staff has been psychiatry. There has been some difficulty in recruiting psychiatrists, exacerbated by the changes in the physicians' draft laws. This has been offset by utilizing local psychiatrists on a part-time contract basis. There also appears to be expanding and strengthened relationships with local CMHC's and Health Department Guidance Clinics. Oklahoma University Medical Center, the State Institutions of the Department of Mental Health, the Menninger Foundation, the State Hospital at Fort Smith, Arkansas, and other major centers are being utilized.

2. Clinical Services

While Oklahoma City Area, like all others in the United States, has a critical need for clinical expertise, program development has been broadly based at the local level, with emphasis on evaluation, short term intervention, and support for both preventive programs and the maintenance of chronic patients near or in their own homes.

Unfortunately there are no data for the Area as a whole as to the number of patients receiving direct clinical services. Dr. Schottstaedt's reports on Clinton and Shawnee have been quoted and give details for these Service Units. When the Social Service/Mental Health problem oriented report forms are analyzed, a more complete picture of the utilization of clinical services. The staffing needs in various Service Units are a function of both the epidemeology in the client population and the availability of other resources for the Indian population. When resources are scarce for the population as a whole, and when expertise is needed both in standard clinical backgrounds and in relating to a different cultural group, there are often times when deficits in service delivery seem to be inevitable.

The Oklahoma Area has deployed its resources at the psychiatric and senior clinical level in a decentralized pattern. This has enabled them to retain local personnel, rather than physically exhaust a centrally based team. This process is resulting in outstanding programs at Clinton and Shawnee under Dr. M. F. Schottstaedt and has attracted the attention of one of the few American Indian psychiatrists in the nation, Dr. H. C. Townsley. Dr. James Bonnar, at the Kansas Service Unit, is also initiating what promises to be a comprehensive program in a unique combination of serving a reservation population and a residential college student body and staff.

As the staffs at the other Service Units develop their ability to use psychiatric resources effectively, their support should attract additional specialists. However, one cannot ignore the fact that clinical back-up services are often needed, and the Oklahoma City Area, like most of the other IHS Areas, cannot rest on its laurels, even while it can mark down milestones of growth and accomplishment.

3. Consultation Relationships

In 1973 about two-thirds of the present staffs were available to respond to a questionnaire about the activities in which they were engaged. While these responses provided only estimates of patients seen, they did seem to reflect fairly accurately the consultation activities which were reported to account for an average of about one-half of all staff time (Range 10-70%). 12 - 17% of staff time involves consultations about individual patients. amd about 20% of the staff time on the average is spent in program coordination and planning with other agencies. The table which follows lists the types of agencies and institutions with whom these consultation activities are taking place.

Taking the first line as an example, this table should be read as follows: Eight out of eight professional staff and five out of six paraprofessional staff report consultations with IHS physicians about patients. Four out of eight professional staff and one out of six paraprofessional staff report consultations with IHS physicians about program development.

A second table (see Table B), prepared from the same responses indicates that in spite of the large number of agencies with whom consultation is carried on, the activities are relatively informal. While it is never wise to over manipulate numbers, it appears from the comparison of these two sets

TABLE A

NUMBER OF STAFF REPORTING CONSULTATION WITH VARIED AGENCIES

Agency	Professional Reports (N 8)		Paraprofessional Reports (N 6)	
	Patients	Programs	Patients	Programs
INDIAN HEALTH SERVICE				
IHS Physicians	8	4	5	1
IHS Nurses, Clinic or Hospital	6	6	5	-
IHS Public Health Nurses	7	4	3	2
Other IHS Staff	6	5	2	1
Traditional Healers	1	1	1	1
OTHER MEDICAL RESOURCES				
Private M.D.'s	2	2	2	-
University Hospital	1	1	-	-
State Mental Hospital	8	5	2	2
Psychoanalytic Organization	-	1	-	-
Health Department, Child Guidance Clinics	3	2	-	-
Community Mental Health Centers	3	2	2	1
HUMAN SERVICES AGENCIES				
State and County Welfare	3	3	5	-
BIA Social Services	7	5	5	-
Vocational Rehabilitation	3	2	3	-
SCHOOLS & CHILD CARE				
Public Schools	3	2	3	1
BIA Schools	8	8	4	-
Parochial Schools	-	-	-	-
Headstart Programs	1	1	2	-
Day Care	1	2	-	-
ALCOHOLISM PROGRAMS				
Counselors	6	5	5	5
Detoxification Unit Staff	-	-	1	1
Halfway House Staff	3	1	1	2
LAW ENFORCEMENT & COURTS				
State & Local Courts	5	1	2	-
Local Police & Sheriff	3	1	4	-
Jails	2	-	2	-
Legal Aid Attorneys	2	-	-	-
Youth Services	1	1	-	-
TRIBAL GROUPS & ORGANIZATIONS				
Tribal Leaders	1	2	-	-
Traditional Healers	1	1	1	1
Community Health Representatives	8	7	3	4

of information that approximately 11% of the professional agency consultations are on a regularly scheduled basis, even though 180 such contacts are mentioned, and less than four percent of the paraprofessional agency consultations are planned on a regular basis, even though sisty-five such contacts are mentioned as having occurred. This information suggests that the Oklahoma City Area Mental Health programs are in the earlier stages of service network development. These seem to be a very small percentage of regularly scheduled consultations or contractual arrangements for providing this kind of service.

TABLE B

IHS MENTAL HEALTH STAFF

REGULARLY SCHEDULED OR CONTRACTED CONSULTATIONS

Agency	Professional (N 8)	Paraprofessional (N 6)
IHS Physicians	1	-
Other IHS Staff	2	-
IHS Public Health Nurses	1	-
Private Physicians	2	-
Community Mental Health Centers	1	-
State Hospitals	1	-
BIA Social Service	2	-
BIA Schools	4	-
Public Schools	-	1
Headstart Programs	-	1
Alcoholism Counselors	1	-
Halfway House Staff	2	1
Tribal Leaders	1	-
Community Health Representatives	1	1

C. Staff Training

While some Areas seem to develop intensive training programs of their own (Navajo) or to consistently utilize one training resource (Phoenix), Oklahoma has developed a variety of training resources for its staff. Most of the Mental Health specialists have found that the foundation for their work has been the Social Work/Psychology Procedures Course at Fort Sam Houston, provided mainly for Army paraprofessionals, but available to all branches of the United States Services. This program seems to give special attention to small groups of staff from Oklahoma, training them at no expense other than their travel and housing arrangements while in San Antonio. It is the impression of the Area Chief that upon returning to their Service Units, the Mental Health specialists have more self assurance and a better grasp of their duties, as well as skills to accomplish both clinical and community activities than graduates of the other available programs. The discovery and development of this resource by Mr. Bjork opens new doors to Mental Health training resources for IHS.

Some of the Mental Health staff have taken advantage of the Desert Willow Training Center of IHS which allows for the earning of an Associate of Arts degree, and a few have had the Alcoholism Counselor Training sequence at the University of Utah. Because there is a high general level of education in Oklahoma, recruiting local tribal personnel who have already had one or more years of college work is not as rare as in many Areas. Staff who desire to work toward college degrees are encouraged and helped both through time off from work and tuition grants.

Another training element is provided by senior staff as they supervise their team associates. The supervision provided by psychiatric consultants and social workers of either Mental Health or Social Services Branch tends to be highly individual and emphasizes those elements that are of particular interest and concern to the local Service Unit and the consultant. This results in more efficient local program development.

There have been a number of statewide training programs established by other agencies which have been open to IHS Mental Health staff. Those of the State Department of Health for its Community Guidance staffs have been of particular interest to both professional and paraprofessional IHS staff. Active participation in local workshops is encouraged as well as sponsorship by Service Units and interagency efforts. However, there does not seem to be a plan or sequence of in-service training for all Area staff members. Travel restrictions have diminished opportunities for Area wide training programs. One meeting per year of Area wide Mental Health staff seems to be all that present budgets permit.

On the other hand, IHS Mental Health staff has performed some training and educational work for IHS staff, particularly for the Nursing branch. The CHR's also receive some Mental Health training in each of the Service Units as a follow-up to their other class instruction and training programs. Classes and workshops are also offered to school personnel, especially to Headstart staffs and to BIA school personnel at the dormitory level. These in-service training programs are in response to local need and interest, and do not have a general overall framework within which they fit. It is expected that the Mental Health Educator will assist in developing curriculum materials for such training programs as his position becomes better established.

D. Indian Advisory Board Relationships

1. Planning and Coordinated Efforts

As has been described elsewhere, from its inception the Oklahoma Area Mental Health programs have directed their attention to the desires, interests, and expressed needs of the Indian client population. The Area Advisory Board, composed of representatives from all parts of the Area, has been one of the major formal channels for this effort. The Area Advisory Board maintains an office which was first in Tulsa, but has been moved to Oklahoma City in recent years, and is quite active in its overview and recommendations to all Branches of IHS.

As is true in most Areas, there are varying degrees of trust in and skepticism of federal programs amongst Area Board members. As policy, it tends to act conservatively when formal arrangements are involved. This has been described in connection with the evaluation of the major Area position, originaly designated as a Mental Health Coordinator and in 1973 formally changed to that of Mental Health Educator. (See p. 42 and p. 116)

The complex balance of relationships has been sustained through several changes of personnel both on the Advisory Board and in the IHS Area Office. Continued contact and exploration of ways to solve mutual problems and attain shared goals is expected by all parties.

Tribal Mental Health Committees, sometimes subcommittees of larger Health and Welfare Committees are varied in their activity and relationships to Service Unit programs. They do not, as in some Areas, represent components in direct relationship to the Area Board, but are sometimes the channels through which local needs and programs are voiced and transmitted to the Area level.

In a multi-tribal context, it is extremely important to have the support of such organizations as the Area Advisory Board,and the Mental Health Chief takes care to keep them informed of his plans and the activities of his staff as well as keeping open channels for receiving information and opinion from them.

2. Evaluation

One function performed by the Area Indian Advisory Board is to evaluate IHS programs. This provides an external opinion about strengths, weaknesses, practical objectives and long range goals. Since the pattern for these evaluations is one which could well be a model for other Areas, it seems worth while including here

The first document is the sheet labeled "Evaluative Criteria" which states the Advisory Board's objectives and lists the preparatory materials and documents that will be needed. (See page 134).

The second document is the final briefing outline forwarded to the Chief, Mental Health. It consists of an outline of the procedures to be followed in meeting with the Area Board, and the form in which the Board will communicate its findings. (See page 135).

Finally, the third document is the final report of the Indian Advisory Board of its findings. (See pages 136, 137, 138).

This Indian Advisory Board Evaluation procedure can also be utilized at the Service Unit level. Perhaps, in the future a series of such reports may become available to carry forward the processes of evaluation and recording initiated in this project.

EVALUATIVE CRITERIA
FOR
ADVISORY BOARD EVALUATION OF AREA OFFICE BRANCHES

The Oklahoma City Area IHS Advisory Board, Inc., for fiscal year 1974, is evaluating several branches of the Oklahoma City Area Office. The branches selected by the Board for evaluation are:

1) Administrative Services Branch (Contract Health Services)
2) Administrative Services Branch (Leasing of Clinic Space)
3) Personnel Branch (All Functions)
4) Health Education Branch (All Functions)
5) Mental Health Branch (All Functions)
6) Social Service Branch (All Functions)
7) Public Information Branch (All Functions)
8) Sanitation Facilities Construction Branch (All Functions)

The Advisory Board's two primary objectives for this evaluation are as follow:

A. To determine, from a consumer and tribal leadership's point of view, the operational efficiency of the Area Office branches.

B. To provide members of the Oklahoma City Area Advisory Board an in-depth insight to the functional operation of the Area Office branches.

An evaluation schedule of branch offices is attached. Each Branch Chief has been requested to provide the Executive Director and/or Project Director with the following data at least ten working days prior to the evaluation of his branch:

[illegible]anch Functional Statement
b. Job Description of Branch Chief
c. Pertinent excerpt of Federal Manual
d. Pertinent excerpt of IHS Manual
e. Pertinent excerpt of Area Manual
f. Branch Guidelines and Policies
g. Operational Plan for FY-73 and FY-74
h. Monthly Reports (Area and Service Unit's counterparts for FY-73 and FY-74)
i. Audit Reports
j. Data System
k. Budgets
l. Staffing Patterns

METHODOLOGY

1. The Evaluation Team will meet at 9:00 a.m. on the scheduled day of evaluation in the Project Director's office in Indian Health Services, Old Post Office Building.

2. The Team will proceed to the appropriate branch being evaluated. The team w listen to a presentation by the Branch Chief and Section Chiefs of their guidelines, policies, functions, objectives, and operational plan.

3. A brief description on system analysis will be presented by the Branch Chief with flow charts.

4. The Branch Chief will present self-evaluation activities.

5. The Branch Chief will state his branch's overall needs and problems along with his recommendations for improvement.

6. The Branch Chief will discuss his branch's administrative dependency status in relation to other Area Office branches.

7. The Branch Chief will explain his utilization of data in his decision making process.

8. A general discussion will be held between the Branch Chief and the Evaluatio Team to review the material covered.

9. The Evaluation Team will, as a group, write an evaluative report of the particular branch. The report will reflect, from a consumer's and tribal leadership's point of view, both the desirable and undesirable aspects of the branch. Recommendations, if any, will also be contained in this report. This report will be submitted to the Project Director within thirty days af completion of the evaluation. A final report will be submitted by the Evaluation Team at the conclusion of all branch evaluations.

ADVISORY BOARD EVALUATION OF MENTAL HEALTH BRANCH, OKLAHOMA CITY AREA OFFICE

Date of Evaluation: October 30, 1973

Evaluation Committee: Mr. Sylvester Tinker
Mr. Henry Secondine
Ms. Betty Harjo
Mr. Ned Timbo
Reverend Morgan Burgin
Mr. Herbert L. Coley

The Evaluation Committee met at 0900 in the Project Director's Office and at 0915 proceeded to the Mental Health Branch Office.

The Mental Health Branch Chief, Mr. John Bjork, welcomed the Evaluation Committee and presented them with an informal but comphrensive structure of the Mental Health Program.

The committee members were informed of the goals and objectives of this multi-disciplined program which in comparison to other IHS Programs, is still in its infancy. All Mental Health staff personnel are field personnel with the exception of the Branch Chief and Secretary.

The following Service Units have the following Mental Health staff:

Tishomingo	Mental Health Consultant, George Day, MSW Mental Health Specialist, Phyllis Roller, BS
Talihina	Mental Health Consultant, Timothy Nolan, MS Mental Health Specialist, Lynn McAllister, BS
Tahlequah	Mental Health Specialist, Issac Christie, MEd Mental Health Secretary, Wilma Ummerteskee
Claremore	Mental Health Specialist, Vickie Wilkerson, BA Mental Health Secretary, Madeline Narcomey

Clinton	Mental Health Specialist, Arthur Rowlodge Mental Health Secretary, Jobyna Toppah
Lawton	Mental Health Consultant, Richard Downey, MS
Pawnee	Mental Health Consultant, Donald Samson, EDD Mental Health Specialist, Lavina Wichita, LPN Mental Health Secretary, Wilson Moore
Kansas	Mental Health Consultant, Dr. Bonnar
Shawnee	None

An objective of the Mental Health Branch is to have at least a Mental Health Consultant/Specialist and a Mental Health Worker at each Service Unit so as to obtain the overall goal of insuring good mental health to the Indian population.

Due to the infancy of the Mental Health Program, functional statements were not available. Data is at the present time is being gathered but the system is not sophisticated enough to be meaningful at this time.

The Evaluation Committee reviewed progress reports from field personnel.

The Evaluation Committee considers the following to be of major concern:

a. There is a dire need for Mental Health Programs to be instituted within the BIA controlled boarding schools. The fact that there must also be a willingness on the part of BIA officials is appreciated.

Recommendation: That the Mental Health Branch place high priority on instituting such programs within BIA boarding schools within the immediate future.

b. There is a need for consumer awareness of the Mental Health Program.

Recommendation: That the Chief, Mental Health Branch provide training and technical guidance to the Area Board Mental Health Educator for a half a day each week and that this training be provided for one year.

That local health boards invite the mental health personnel assigned to their service unit area to attend their board meetings and make presentations of their activities within the communities.

c. There appears to be very inadequate funding of the Mental Health Branch which results in understaffing.

Recommendation: That adequate funds be requested so as to provide the staffing of two mental health personnel at each service unit.

The committee is aware of the limitations of services imposed by inadequate funding. The Area Board is willing to assist in anyway possible in securing more resources for increasing the scope of the Mental Health Program and especially so in the preventive type programs.

The committee was well pleased with the overall operation of the Branch Office. The Branch Chief appeared to be very knowledgeable of his position. He appeared most capable to successfully manage the Mental Health Program. He appeared most willing to work with the Area Board Health Educator and to provide the training and guidance requested.

V. Summary

A. Achievements

1. The most dramatice achievement in the Oklahoma City Area over the last four years has been the increase in the number of staff and the decentralisation of the program in most of their phases. From a single circuit riding psychiatrist, it has expanded to a total of twenty-five staff members by the end of the fiscal year 1973-1974. All Service Units have at least one Mental Health Worker of Indian background or a professional with training at the master's degree level. At Clinton, Lawton, Shawnee, Tahlequah and Tishomingo psychiatric consultation is available on a regularly scheduled basis, while at the Kansas Service Unit there is a psychiatrist full time. The stability of staff and very low turn-over rate for all disciplines except psychiatrists should be noted.

2. A particular job description has been developed to meet local needs. In introducing Mental Health Specialists to the Area, provision for training is made through a job at entry level which calls for clerical skills. This provides the Mental Health team with the services of a clerk or secretary but also introduces the paraprofessional to graduated responsibilities and special training. This is a particularly useful step in developing a team of experienced and trained personnel. It provides for entry level employment and opportunities for upward mobility along the career lattice being developed nationally.

3. In close collaboration with the Indian Area Advisory Board a second unique position has been developed. The Mental Health Educator position is jointly supported. This allows a person of Indian background to be selected and hired through the Area Advisory Board, with a special mission to work with tribal and community groups in educational and informational capacities focused on Mental Health. These services are usually shared with those of the General

Health Educator position in other Areas, or are undertaken by the regular staff of Mental Health programs. The full time position, and its direct relationship with tribal councils and tribal leadership groups as well as the Area Board should prove useful in a mutual exchange of information and in viewpoints about Mental Health and the nature and needs of the Area Mental Health programs.

4. Training for Mental Health Specialists has been developed through utilizing the Social Work/Psychology Procedures Course given by the United States Army at Fort Sam Houston, with coordination from the Area Chief. Use is also made of the Desert Willow Training Program and of the University of Utah Alcoholism Training Program with its special emphasis on American Indian needs. Staff are also supported in utilizing various Oklahoma institutions of higher education and inter-agency training programs at the State and local level.

5. Cooperation with Social Services at the Area level, and in those Service Units where the Social Service Branch has Social Workers, has been good. In some instances the Social Service personnel provide supervision to the Mental Health Specialists when a Mental Health professional staff member is not available.

6. There has been interest in and leadership offered in the utilization of local resources for a variety of human services for Indian people. Increasingly effective liaison with a variety of agencies has developed as staff has been added to the various Service Units.

7. Public schools have been receiving some consultation services as well as BIA schools. At Pawnee, Headstart programs are receiving emphasis, and at Lawton, Special Education screening is being made available. Consultation to BIA high schools and dormitory programs has been repeatedly offered, and in spite of difficulties, some programs have been developed both as treatment for disturbed youth and to foster normal social growth.

8. The support to the Cheyenne Arapaho Lodge has enabled a unique and effective rehabilitation center for alcoholics to develop and establish its practicality.

B. Problems Yet To Be Resolved

1. In the expansion of the Mental Health programs and the development of a fairly stable staff the decentralization has been an excellent move. However, the need for adequate clinical services and backup consultation and referral resources has not yet been adequately developed throughout the Area.

While there is continual progress, at some point the balance between clinical and community services must be matured. Plans for moving in this direction need to be made more explicit. Budget uncertainties and IHS personnel affected recruiting selectively. Developing part time contracts with individuals who not only possess clinical skills but also have an interest in the specific needs and cultural backgrounds of the Indian population to be served is a solution which is at least partially effective and needs to be explored further. The Area Advisory Board judges this program as in its infancy and IHS needs to nurture it through its developmental crises.

2. There has been difficulty in establishing programs due to changing support and interests at the Area and Service Unit level. At times the Chief of Mental Health Services has been unable to develop continuity of program emphasis because of these changes in administration, and at times it has appeared as though as much energy and attention needed to be expended within IHS as outside of it in developing understanding and support for effective work. Where individual staff have been strong and knowledgeable, as in the case of the Clinton Consultant and Mental Health Worker, individually excellent programs have been developed in the Indian community even though the IHS physicians and other staff seem not to have time or energy to devote to Mental Health activities. However, this outcome depends on the skills of the staff and does not seem to be generalizable throughout the Area.

3. Kansas Units seem remote from the Oklahoma activities. This is in part due to the fact that they are the only true Reservations in this IHS AREA. The basic problem of how to organize and develop services within a system where the general plans and explicit administrative rules are formulated for reservations, while the population to be served does not live on reservations, is a dilemma that neither IHS nor its Mental Health programs have solved. There is not only a multiplicity of tribes being served in the Oklahoma City Area but also the individual status of the peoples, their degree of assimilation, and their varied cultural backgrounds are not always explicitly understood nor taken into account in Service Unit programs or IHS planning generally. In fact, these issues plague the tribal organizations as well as IHS. Attempts to work out intertribal positions on many issues, some of which directly effect both the mental health of the population and the development of programs are complex and sometimes move more slowly than professional staff would like.

4. Until these issues can be seen more clearly and more explicitly, it is difficult to know when to develop Indian services for Indian people and when to emphasize the rights of Indian people to adequate and effective help from local, state and other federal resources. There is much ambivalence over this question throughout the Indian leadership. The scars of discrimination and the remnants of federal paternalism and its counterpart of dependency are much more insidious in this ambivalent situation than in cases where there are clear-cut residential boundaries and limitations, as well as the benefits of federal statutes and special treaty rights. IHS programs and leadership must pick their way between the storms of separatism and the loss of identity and special rights.

It is quite clear that the state and local systems for providing health services in general, and mental health services in particular, are not adequate to meet the needs of the total population as presently established and distributed. It is also fairly clear that the present IHS staff and programs are not adequate in themselves for the Indian population. Without making use of a network of local and state resources in cooperative fashion, it is questionable whether any Service Unit could provide adequate Mental Health programs. Unlike other Areas where reservations create an interface between state and federal authority, Oklahoma IHS staff can decide whether they are a primary or supportive resource. However, the decision is not always clear to either staff or the Indian clientele. It is imperative that this ambivalence be resolved; it is probable that this can only happen as the local tribes gain a clearer idea of their own needs and formulate explicit plans to meet them. The Mental Health program's staff can provide a measure of leadership, but most probably can also provide an even larger measure of support for local tribal endeavors to resolve their own ambivalence and learn how best to utilize all available resources, including IHS. Struggling with these issues is an ongoing problem.

5. As a part of this issue, the problem of the best ways to work with BIA schools plagues every Service Unit. This is a long standing problem, which has its counterparts in every Area. It seems more acute in Oklahoma because of the large number of BIA schools established within the Area. It is fairly commonly accepted that almost the only Oklahoma Indian youths sent to these schools are those who come from disturbed homes or who have been offered an alternative placement because of social and emotional adjustment problems of a type which often lead to delinquency. This also seems to be true for many of those sent from distant reservations. However, there is also a proportion of young people who have no other access to education and whose emotional

problems originate in homesickness and in reaction to institutional living.

The knowledge and expertise of Mental Health staff tends to focus as much on preventive programs and on the context in which disturbed behavior appears, as it does on individual treatment for the student. However, recommendations that affect the context are not always palatable to BIA staff or congruent with BIA policies. To what extent relationships between BIA school personnel and IHS Mental Health staff can be developed may depend upon administrative decisions at a level outside of the IHS Area Mental Health programs.

The high priority placed by the Area Advisory Board on developing solutions to the BIA school problems reflects a genuine and sometimes altruistic concern. The results of the problems of disturbed youth are plainly visible. However, it is also easy to see how school problems alone could consume all the manpower and talent IHS has available for Mental Health programming. It is also not clear how to organize Mental Health services to the BIA schools for maximum effectiveness. At the Area level decisions need to be made from time to time which deploy resources for maximum effectiveness without shortchanging other services to the resident population of all ages. This will remain an ever present problem with no easily attainable solution in sight in this or any other Area.

6. The problems of adequate documentation and records of services provided is in part being addressed by the adoption of a computerized Mental Health/Social Service Report Form. However, narrative accounts of activities at all levels do not follow standard formats and are highly variable in the amount of information transmitted. This, too, is a problem shared by many Areas and has created fewer difficulties in the Oklahoma Area because of the stable personnel patterns. Nevertheless, thought should be given to the advantages of objective and adequate descriptions of programs and services.

7. A major problem yet to be resolved is that of developing plans, not in terms of IHS Budgets and capacity but with an overview of the entire Area's Indian population, and how best to complement and supplement the other Mental Health resources available. This is a complex task and is a next step in the developmental growth of the program.

Basic decisions defining the realistic perimeters of such a plan require discussion at many levels within and outside of IHS. Within IHS must be reconciliation of "Reservation based services" with the realities that neither Oklahoma nor Alaska serve populations confined to reservations.

a. There must be resolution of the question of whether or not it is illegal to serve that 16% of the Indian population which lives in cities that do not have IHS facilities, for instance. Perhaps, it is not a question of legality but of budget or of apparent availability of alternative agencies.

b. What are the epidemiologic facts about need for mental health in terms of problems and diagnostic categories, geographic distribution and prevalence in different age groups?

c. What are the other resources and how could networks be evolved by inter-agency agreement and informal coordination?

d. How do tribal and intertribal organizations perceive their own needs and how do they assess the resources available to them?

e. What types of expertise can IHS supply and how can it deploy them?

8. Emphasis on interagency cooperation and consultation is increasing in the Oklahoma City Area. However, the small percentage of scheduled consultations (pp. 128-9) suggests that heavy reliance is placed on chance encounters and emergencies to bring about exchanges. This is a necessary developmental

phase, but it should be seen as preparatory to the next growth stage. This problem is one which will not be simply or quickly solved, but consideration of it should be anticipated in the next five years of program growth.